
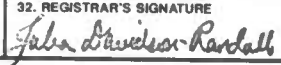


96 06501

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOBOYNY MITCHELL				2. DATE OF DEATH MONTH FEB DAY 17 YEAR 1996		3. TIME OF DEATH 0545 M	
4. SOCIAL SECURITY NUMBER 220-26-1285		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 4, 1914	8. BIRTHPLACE (State or Foreign Country) Md.		
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Talbot		10c. CITY, TOWN OR LOCATION Easton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 61 PLEASANT ALLEY				10f. ZIP CODE 21601		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY DOMESTIC			
17. FATHER'S NAME (First, Middle, Last) HENRY FLETCHER				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH THOMAS			
19a. INFORMANT'S NAME (Type/Print) WILLIAM FLETCHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 SCOTT TOWN RD. QUEENSTOWN, MD. 21658			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RICHARDS MEM. PARK 2/24/96 EASTON, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WILLIAMSON-FLUHARTY FUNERAL SERVICE 319 E. DOVER ST. EASTON, MD. 21601			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):					
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 8 Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William Fair				29c. LICENSE NUMBER 04323F		29d. DATE SIGNED (Month, Day, Year) 2/17/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Fair 19 Franklin St. Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06502

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARION ELIZABETH Murphy				2. DATE OF DEATH MONTH 2 / DAY 18 / YEAR 96		3. TIME OF DEATH 2:05 P M	
4. SOCIAL SECURITY NUMBER 088-09-2524		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) APR. 2, 1912	
8. BIRTHPLACE (State or Foreign Country) NEW YORK				9a. FACILITY NAME (If not institution, give street and number) WILLIAM HILL MANOR		9b. CITY, TOWN OR LOCATION OF DEATH EASTON	
9c. COUNTY OF DEATH TALBOT				10a. STATE MARYLAND		10b. COUNTY TALBOT	
10c. CITY, TOWN OR LOCATION EASTON				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 501 DUTCHMAN'S LANE	
10f. ZIP CODE 21601				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES XX				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) ARTHUR G. MEYERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH B. PFEIFFER			
19a. INFORMANT'S NAME (Type/Print) RUTH M. HOCTOR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 1038, ST. MICHAELS, MD 21663			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ST. MARY'S CEMETERY 2-22 FLUSHING, NEW YORK		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Keith Pluggin, CFSP				22. NAME AND ADDRESS OF FACILITY FELLOWS, HELFENBEIN & NEWNAM FUNERAL H. 200 S. HARRISON ST., EASTON, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHF Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. coronary artery disease c. atherosclerosis d. Approximate Interval Between Onset and Death hours years years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ruth M. Hoctor M.D.				29c. LICENSE NUMBER 025750		29d. DATE SIGNED (Month, Day, Year) 2-19-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert B. Sanchez M.D. 508 Falkenhill Ave Easton, MD 21601							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

557



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06503

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAWRENCE GUSTAV NYGREN				2. Date of Death Month Day Year FEB 12 1996		3. Time of Death 12:30 pm	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN, MD		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 095-03-4225		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-08-1910	9. Birthplace (State or Foreign Country) Minnesota
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State DE		10b. County SUSSEX		10c. City, Town or Location DAGSBORO			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number BOX 248 POINT FARM				10f. Zip Code 19939		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2YR				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNION EXECUTIVE AFL-CIO		16b. Kind of Business/Industry BUSINESS UNION	
	17. Father's Name (First, Middle, Last) CARL PETROS NYGREN				18. Mother's Name (First, Middle, Maiden Surname) AUGUSTA HOLLAND BROBERG			
	19a. Informant's Name/Relationship (Type, Print) PEARL FREEMIRE NYGREN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 248 POINT FARM DAGSBORO, DE 19939			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. GEORGE'S CEMETERY		Date 2-15	20c. Location - City or Town, State CLARKSVILLE, DE		
	21. Signature of Funeral Service Licensed 				22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD BOX 100 THATCHER ST FRANKFORD, DE 19945			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SUDDEN DEATH Due to (or as a consequence of): b. HEART DISEASE Due to (or as a consequence of): c. POOR LV FUNCTION SICK SINUS SYNDROME d. SEVERE Due to (or as a consequence of): Approximate Interval Between Onset and Death MINUTES YEARS							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES mellitus, CVA, Hypothyroid							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier 				29c. License number C1-0001597		29d. Date signed (Month, Day, Year) 2.14.96	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. SHORMAN MD 310 OLD CHAWANEE RD MILAND DE 19963				31. Date filed (Month, Day, Year) FEB 15 1996			
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

18. August 1918

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06504

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM NORKIN				2. Date of Death Month February Day 15 Year 1996		3. Time of Death 5:25 PM	
	4a. Facility Name (If not institution, give street and number) 1327 CORAL SEA DRIVE				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 124-09-2717		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 4, 1920	9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1327 CORAL SEA DRIVE				10f. Zip Code 20851		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER/SALESMAN		16b. Kind of Business/Industry HARDWARE		
17. Father's Name (First, Middle, Last) MORRIS NORKIN				18. Mother's Name (First, Middle, Maiden Surname) JENNY SHAPIRO				
19a. Informant's Name/Relationship (Type, Print) KENNETH NORKIN (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 HICKORY AVE-TAKOMA PARK, MD 20912				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID		Data 2-18-96		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLEPIKE-ROCKVILLE, MD 20852				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. ACUTE MYOCARDIAL INFARCTION</p> <p>Due to (or as a consequence of):</p> <p>b. CORONARY ATHEROSCLEROSIS</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Approximate interval Between Onset and Death</p> <p>IMMEDIATE</p> <p>10 Years</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. TYPE II DIABETES MELLITUS TRIGEMINAL NEURALGIA HYPERTENSION								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Attending		29c. License number D35045		29d. Date signed (Month, Day, Year) February 16, 1996		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) PHILIP HENJUM, MD 3416 Olandwood Court #200 Olney, MD 20832								
31. Date filed (Month, Day, Year) FEB 22 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

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The tenth of these is the fact that the
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The eleventh of these is the fact that the
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The twelfth of these is the fact that the
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The sixteenth of these is the fact that the
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The seventeenth of these is the fact that the
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The eighteenth of these is the fact that the
 of the system is not a simple one.

96 06505

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <u>SHirley L. Newland</u>				2. DATE OF DEATH MONTH <u>Feb</u> DAY <u>15</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>2:30</u> P M	
4. SOCIAL SECURITY NUMBER <u>573-42-4548</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>67</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Nov. 4, 1928</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Holy Cross Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u>	
9c. COUNTY OF DEATH <u>MONTGOMERY</u>				10a. STATE <u>Maryland</u>			
10b. COUNTY <u>Montgomery</u>				10c. CITY, TOWN OR LOCATION <u>Silver Spring</u>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>1400 Fenwick Lane, #407</u>			
10f. ZIP CODE <u>20910</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>		16b. KIND OF BUSINESS/INDUSTRY <u>None</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Howard D. Dyson</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary L. Hawkins</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Alverta Hawkins (Sister)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2810 Evarts St., NE, Washington, DC 20018</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Brooke Grove Cemetery 2/23 Gaithersburg, MD</u>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>George R. Snowden</u>				22. NAME AND ADDRESS OF FACILITY <u>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>METASTATIC Lung Cancer</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Early Breast Cancer</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. V. Baccia, MD</u>				29c. LICENSE NUMBER <u>Dr9675</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/16/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Ralph V. Baccia, MD 9707 Modern Center B Rockville</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 20 1996</u>				32. REGISTRAR'S SIGNATURE <u>John A. Anderson-Randall</u>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06506

Amended #9a, 10e, 19b, 2/20/96, MRT, Montgomery County
 FOR
 1 - STATE
 REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donald F. Ormsby				2. DATE OF DEATH MONTH DAY YEAR February 10, 1996		3. TIME OF DEATH 8:30 AM	
4. SOCIAL SECURITY NUMBER 323-14-9880		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 20, 1916	
8. BIRTHPLACE (State or Foreign Country) Illinois		9a. FACILITY NAME (If not institution, give street and number) 15100 Interlachen Drive, #423 #424		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15100 Interlachen Drive, #423 #424		10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Officer		16b. KIND OF BUSINESS/INDUSTRY Military			
17. FATHER'S NAME (First, Middle, Last) Adelbert F. Ormsby				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah McGaw			
19a. INFORMANT'S NAME (Type/Print) Anna K. Ormsby				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 Interlachen Drive, #423, Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) February 13, 1996 Arlington National Cemetery		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Anemia DUE TO (OR AS A CONSEQUENCE OF): c. Liver Failure DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara R. Kutta M.D. Ph.D.</i>				29c. LICENSE NUMBER D39190		29d. DATE SIGNED (Month, Day, Year) February 12, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Garrett Reilly, M.D., Ph.D. 3418 Olandwood Court Olney, Maryland 20832							
31. DATE FILED (Month, Day, Year) FEB 14 1996				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06507

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM HENRY OLIVER				2. Date of Death Month Day Year February 19 1996		3. Time of Death 3:00 PM	
	4a. Facility Name (If not institution, give street and number) 11807 CEDARVILLE ROAD				4b. City, Town, or Location of Death BRANDYWINE		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 337-32-9220		6. Sex XX M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 13, 1939	
	Usual Residence of Decedent		10a. State MARYLAND		10b. County PRINCE GEORGE'S		10c. City, Town or Location BRANDYWINE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11807 CEDARVILLE ROAD		10f. Zip Code 20613		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER/OPERATOR		16b. Kind of Business/Industry CONSTRUCTION CONTRACTOR			
	17. Father's Name (First, Middle, Last) WILLIAM MURPHY OLIVER				18. Mother's Name (First, Middle, Maiden Surname) CORA TAYLOR			
	19a. Informant's Name/Relationship (Type, Print) MIRIAM C. OLIVER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11807 CEDARVILLE ROAD, BRANDYWINE, MARYLAND 20613			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS FEB. 23, 1996		20c. Location - City or Town, State WALDORF, MD			
	21. Signature of Funeral Service Licensee MARK G. BROHAWN M00053		22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Generalized Atherosclerotic Cardio-Vascular Disease years Due to (or as a consequence of): b. Hypertension years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s/p cerebro-vascular accident 10 yrs ago, with dysphagia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature] MD				29c. License number D25925		29d. Date signed (Month, Day, Year) February 20, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. BERGER MD #205, 7720 Wisconsin Ave., Bethesda, Md 20814								
31. Date filed (Month, Day, Year) FEB 23 1996		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

7. The seventh part of the report deals with the results of the work during the year and the progress of the work during the year.

8. The eighth part of the report deals with the results of the work during the year and the progress of the work during the year.

96 06508

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEATRICE E PALMER				2. DATE OF DEATH MONTH 02 DAY 01 YEAR 96		3. TIME OF DEATH 0819 M	
4. SOCIAL SECURITY NUMBER 214-32-1452		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-16-18	
8a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				8b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		8c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Snow Hill		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 203 Commerce St.				10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) Clerk Aide		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk Aide		16b. KIND OF BUSINESS/INDUSTRY Social Services			
17. FATHER'S NAME (First, Middle, Last) John Palmer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Loura Crippen			
19a. INFORMANT'S NAME (Type/Print) Charles Palmer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Chacford Lane Willingboro, NJ. 08046			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Wesley		DATE 2/7/96		20c. LOCATION — City or Town, State Snow Hill, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Keith E. Wharton				22. NAME AND ADDRESS OF FACILITY Wharton F/H 22171 Wharton Rd. Accomac, Va. 23301			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, NON-INSULIN DEPENDENT							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John T. Bulkeley, M.D. D.M.E.				29c. LICENSE NUMBER D03599		29d. DATE SIGNED (Month, Day, Year) 02-01-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) FEB 15 1996				32. REGISTRAR'S SIGNATURE John Davidson Harrell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/10/1988

10/10/1988

10/10/1988

10/10/1988

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Earl Donald Powell				2. DATE OF DEATH MONTH DAY YEAR Feb 21, 1996		3. TIME OF DEATH 9:15 P M	
4. SOCIAL SECURITY NUMBER 185-30-0155		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 19, 1929	
8. BIRTHPLACE (State or Foreign Country) Meadville, Pa				9. FACILITY NAME (If not institution, give street and number) Residence 9106 Trumps Hill Road			
10. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro				11. COUNTY OF DEATH Prince George's			
12. RESIDENCE OF DECEDENT				13. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
14. STATE Maryland		15. COUNTY Prince George		16. CITY, TOWN OR LOCATION Upper Marlboro		17. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
18. STREET AND NUMBER 9106 Trumps Hill Road				19. ZIP CODE 20772		20. CITIZEN OF WHAT COUNTRY? United States	
21. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector		27. KIND OF BUSINESS/INDUSTRY Western Electric			
28. FATHER'S NAME (First, Middle, Last) Wilford Joseph Powell				29. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Hanzi			
30. INFORMANT'S NAME (Type/Print) Delores Anne Powell				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 Trumps Hill Road, Upper Marlboro, Md 20772			
32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery Feb 26, 1996		34. LOCATION — City or Town, State Cheltenham, Maryland			
35. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				36. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic cancer of tongue DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. _____ b. _____ c. _____ d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic blood loss anemia secondary to intestinal angiodysplasias							
37. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		38. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
39. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		40. DATE OF INJURY (Month, Day, Year)		41. TIME OF INJURY M		42. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				44. DESCRIBE NOW INJURY OCCURRED			
45. LOCATION (Street and Number or Rural Route Number, City or Town, State)				46. DATE SIGNED (Month, Day, Year) 2/22/96			
47. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				49. LICENSE NUMBER D13634		50. DATE SIGNED (Month, Day, Year) 2/22/96	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter R. Gaze, MD, 900 Bastgate Rd #300, Annapolis, MD 21401							
52. DATE FILED (Month, Day, Year) FEB 27 1996				53. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06510

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Wade Phillips		2. Date of Death Month: February Day: 26 Year: 1996		3. Time of Death 1:37pm
	4e. Facility Name (If not institution, give street and number) Physicians Memorial Hospital		4b. City, Town, or Location of Death La Plata		4c. County of Death Charles
Funeral Director	5. Social Security Number 235-16-8212	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 16 1910		9. Birthplace (State or Foreign Country) West Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Charles
	10c. City, Town or Location Waldorf		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 4043 Parker Court		10f. Zip Code 20602		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Grocery Store		
	17. Father's Name (First, Middle, Last) Zalma Phillips		18. Mother's Name (First, Middle, Maiden Surname) Birdie Boyles Phillips		
	19e. Informant's Name/Relationship (Type, Print) Terry L. Phillips (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4043 Parker Court Waldorf, MD 20602		
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery		20c. Location - City or Town, State Parsons W. Va.
	21. Signature of Funeral Service Licensee <i>John A. Elexson</i>		22. Name and Address of Facility Barb-Jeffrey Funeral Home 312 Main Street Parsons, West Virginia		
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac Arrest + failure</i> Due to (or as a consequence of): b. <i>Hypertension and Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): c. <i>Chronic Urinary tract infection</i> Due to (or as a consequence of): <i>Benign Prostatic Hyperplasia</i>				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Arthritis, Scoliosis.</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> PER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) —		28b. Time of Injury — M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred —		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —		28f. Location (Street and Number or Rural Route Number, City or Town, State) —		
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <i>Shadur</i>		29c. License number D - 00560		29d. Date signed (Month, Day, Year) 2/26/96
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirendra Bhaduri M.D. 6 Post Office, P O Box 1437, Waldorf, MD 20604				
State Registrar	31. Date filed (Month, Day, Year) FEB 27 1996		32. Registrar's Signature <i>John A. Elexson</i>		

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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96 06511

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) JAMES EUGENE PERKINS, SR.				2. DATE OF DEATH MONTH FEBRUARY DAY 25 YEAR 1996		3. TIME OF DEATH 7:05 a.m.	
4. SOCIAL SECURITY NUMBER 184-24-0975		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 3, 1931	
9a. FACILITY NAME (If not institution, give street and number) 1009 SPRUCE STREET				9b. CITY, TOWN OR LOCATION OF DEATH WALDORF		9c. COUNTY OF DEATH CHARLES	
10a. STATE MARYLAND				10b. COUNTY CHARLES		10c. CITY, TOWN OR LOCATION WALDORF	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1009 SPRUCE STREET				10f. ZIP CODE 20601		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREA		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER/OPERATOR		16b. KIND OF BUSINESS/INDUSTRY MARINE SALES	
17. FATHER'S NAME (First, Middle, Last) CLEVELAND CLARENCE PERKINS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LEILA FINLAND			
19a. INFORMANT'S NAME (Type/Print) ALICE MARIE PERKINS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 SPRUCE STREET, WALDORF, MARYLAND 20601			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS' CEM. 2/28		20c. LOCATION — City or Town, State CHELTENHAM, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark G. Brohawn</i> MARK G. BROHAWN M-00053				22. NAME AND ADDRESS OF FACILITY THE HUNTT FUNERAL HOME, INC. P.O. BOX 156 WALDORF, MARYLAND 20604			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Cancer Colon							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas L. Fieldson MD</i>				29c. LICENSE NUMBER 001923		29d. DATE SIGNED (Month, Day, Year) FEBRUARY 26, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS L. FIELDSON BRANDYWINE WALDORF CLINIC, BRANDYWINE MARYLAND 20613-5907							
31. DATE FILED (Month, Day, Year) FEB 27 1996		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1/10/23

96 06512

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Frederick Painter				2. DATE OF DEATH MONTH DAY YEAR February 25, 1996		3. TIME OF DEATH 6:15 A. M	
4. SOCIAL SECURITY NUMBER 219-03-4608		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 27, 1910		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) P.O. Box 487				9b. CITY, TOWN OR LOCATION OF DEATH California		9c. COUNTY OF DEATH St. Mary's	
10a. STATE Maryland				10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION California	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER P.O. Box 487				10f. ZIP CODE 20619		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Real Estate		16b. KIND OF BUSINESS/INDUSTRY Mobile Home Sales			
17. FATHER'S NAME (First, Middle, Last) Albert Painter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Sappington			
19a. INFORMANT'S NAME (Type/Print) Alberta Calvert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 487, California, Maryland 20619			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Charles Memorial 2/28/96		20c. LOCATION — City or Town, State Leonardtown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward N. Brinsfield, Jr. M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Coronary Artery disease					Approximate Interval Between Onset and Death 5 years
		b. Cardiac Arrest					5 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. Aspiration Pneumonia - Recurrent					6 months
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Shanti				29c. LICENSE NUMBER DIS369		29d. DATE SIGNED (Month, Day, Year) 2/27/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Umed K. Shah, M.D. Shanti Medical Center, Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) FEB 28 1996				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Amended #2, 2/22/96, per DR., MRT, Montgomery County

96 06513

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARTHA L. PURVIANCE				2. DATE OF DEATH MONTH FEB DAY 18 YEAR 1996		3. TIME OF DEATH 130 A M	
4. SOCIAL SECURITY NUMBER 577-60-1736		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 25, 1916	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3701 International Drive #738				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Support Personnel		16b. KIND OF BUSINESS/INDUSTRY Criminal Division Department of Justice			
17. FATHER'S NAME (First, Middle, Last) William Buff Purviance				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Marguerite Purvines			
19a. INFORMANT'S NAME (Type/Print) Chris D. Purviance				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 South Avenue #B1 Secane, Pennsylvania 19108			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 2/21/96 Alexandria, Virginia		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic adenocarcinoma of the lung DUE TO (OR AS A CONSEQUENCE OF): b. adenocarcinoma of the lung DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death months years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Martha S. Saavedra				29c. LICENSE NUMBER P41173		29d. DATE SIGNED (Month, Day, Year) 2-19-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martha S. Saavedra, 3701 International Drive, Silver Spring, Md.							
31. DATE FILED (Month, Day, Year) FEB 22 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06514

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gustava Perec

2. Date of Death

Feb. 17, 1996

3. Time of Death

11:00 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3320 Gleneagle Dr. Apt B1

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

215-38-4820

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 7, 1899

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3320 Gleneagle Dr. Apt B1

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Jewelry Wholesale

17. Father's Name (First, Middle, Last)

Meyer Peritz

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Harold Sobel/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7420 West Lake Terr Apt 104 Bethesda, MD 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 2/18

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute MI

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Aortic Stenosis

HTN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43202

29d. Date signed (Month, Day, Year)

February 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Ozanne-Blankford MD 3305 N. Leisure world Blvd Silver Spring MD 20906

State
Registrar

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

John Andrew Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

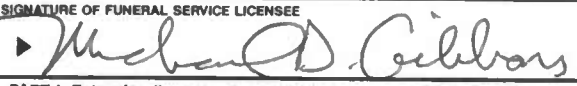
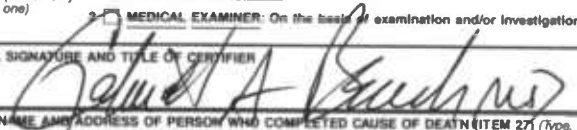

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 06515

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Abbie Shea Prendergast				2. DATE OF DEATH MONTH DAY YEAR February 18, 1996		3. TIME OF DEATH 1:40 P. M.	
4. SOCIAL SECURITY NUMBER 071-18-1883		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 23, 1922	
9a. FACILITY NAME (If not institution, give street and number) Mediplex Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 9301 Ironhorse Lane				10f. ZIP CODE 20879		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Drug Counselor		16b. KIND OF BUSINESS/INDUSTRY Psychiatric Hospital			
17. FATHER'S NAME (First, Middle, Last) Daniel Jeremiah Shea				18. MOTHER'S NAME (First, Middle, Maiden Surname) May Bonnet			
19a. INFORMANT'S NAME (Type/Print) Jera P. Verne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9301 Ironhorse Lane, Gaithersburg, Maryland 20879			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		DATE 2/19		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): c. Peripheral Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30692		29d. DATE SIGNED (Month, Day, Year) February 19, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gabriel A. Berrebi, M.D., 15200 Shady Grove Road, Suite 305, Rockville, MD. 20850							
31. DATE FILED (Month, Day, Year) FEB 21 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06516

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dorinne Phillips</i>		2. Date of Death Month <i>Feb.</i> Day <i>17</i> Year <i>96</i>		3. Time of Death <i>3:45 AM</i>
	4a. Facility Name (If not institution, give street and number) <i>Allegis Health Services-Bethesda</i>		4b. City, Town, or Location of Death <i>Bethesda</i>		4c. County of Death <i>Montgomery</i>
Funeral Director	5. Social Security Number <i>061-18-3312</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>72</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>12/25/23</i>		9. Birthplace (State or Foreign Country) <i>Poland</i>		
Usual Residence of Decedent					
10a. State <i>Md.</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Bethesda</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>5721 Grosvenor Lane</i>			10f. Zip Code <i>20814</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Beautician</i>		16b. Kind of Business/Industry <i>Private</i>	
17. Father's Name (First, Middle, Last) <i>Hyman Borenstein</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Mark Phillips</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>131 Treehaven St. Gaithersburg, Md. 20878</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metropolitan Crematory</i>		20c. Location - City or Town, State <i>2/17/96 Alexandria, Va.</i>	
21. Signature of Funeral Service Licensee <i>Edward Sagel</i>		22. Name and Address of Facility <i>Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <i>Sepsis</i> Due to (or as a consequence of):					
b. <i>pneumonia, probably 2° aspiration</i> Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's disease</i>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homocide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>David A. Bass MD</i>		29c. License number <i>D23911</i>		29d. Date signed (Month, Day, Year) <i>February 17, 1996</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David A. Bass MD 9410 Old Georgetown Rd. Bethesda Md. 20814</i>					
31. Date filed (Month, Day, Year) <i>FEB 20 1996</i>		32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN DOWNING PHELPS				2. DATE OF DEATH MONTH February DAY 14, YEAR 1996		3. TIME OF DEATH 1:50A M	
4. SOCIAL SECURITY NUMBER 496-24-4433		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 3, 1927	
8. BIRTHPLACE (State or Foreign Country) Missouri				9a. FACILITY NAME (If not institution, give street and number) VA Maryland Health Care Systems		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Churchville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3005 Rolling Green Drive	
10f. ZIP CODE 21028				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII / Korea				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrical Engineer		16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) Herbert Camille Phelps				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva May Paugh			
19a. INFORMANT'S NAME (Type/Print) P. Elizabeth Phelps				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Rolling Green Drive, Churchville, Md. 21028			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 2/20/96		20c. LOCATION — City or Town, State West Chester, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John L. McComas</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): c. High Blood Pressure DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 days 10 years Unknown							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. DATE SIGNED (Month, Day, Year) 2/14/96	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas A. Biondo M.D.</i>				29c. LICENSE NUMBER D42800		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS A. BIONDO, M.D. VA Maryland Health Care Systems, Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06518

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TERESA D.

PIERNE

2. Date of Death

Month FEB Day 18 Year 1996

3. Time of Death

4:15

4a. Facility Name (If not institution, give street and number)

Bel Air Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

215-44-2353

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 21, 1899

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

322 Old Joppa Rd.

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis (u/k) DeBarbieri

18. Mother's Name (First, Middle, Maiden Surname)

Rose (u/k) Dondero

19a. Informant's Name/Relationship (Type, Print)

Andrew C. Pierne - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 Old Joppa Rd., Fallston, Md. 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park 2-22-96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Stephen A. Hughes

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
50 W. Broadway St., Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Scott Haswell MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

February 19, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Haswell 2 North Ave Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Bernice Elizabeth Philyaw</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 13, 1996</i>		3. TIME OF DEATH M <i>8:10A</i>	
4. SOCIAL SECURITY NUMBER <i>578-60-2295</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>54</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8-17-41</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Doctor's Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i>		9c. COUNTY OF DEATH <i>Prince George's</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Upper Marlboro</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>3502 Hallowsay South</i>				10f. ZIP CODE <i>20772</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (9-12) 12th</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Collection Agent</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Government</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Unknown</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lucille Jordan</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Hardy Philyaw, Jr/Husband</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3502 Hallowsay South, Upper Marlboro 20772</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Sand Hill Cemetery 2/21</i>		20c. LOCATION — City or Town, State <i>Whitestocking, NC</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kimberly C. Buscoe-Tonic</i>				22. NAME AND ADDRESS OF FACILITY <i>J. B. Jenkins Funeral Home 7474 Landover Road, Landover 20785</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Sudden Cardiac Event (Arrhythmia & IN FART)</i>							
b. <i>small bowel obstruction</i>							
c. <i>CROHN'S DISEASE (Regional Ileitis)</i>							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elliot, J. O. Pathologist</i>				29c. LICENSE NUMBER <i>MD43864</i>		29d. DATE SIGNED (Month, Day, Year) <i>02/15/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. James Elliott Doctors Community Hospital 8118 Good Luck Rd., Lanham, MD 20706</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 21 1996</i>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

el

250' 19' 42"

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06520

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony Joseph Pisano				2. Date of Death Month Day Year Feb. 13 1996				3. Time of Death 2:35 A.M.		
	4a. Facility Name (If not Institution, give street and number) Manor Care Nursing Home				4b. City, Town, or Location of Death Largo				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 099 16 0985		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 16, 1922		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Greenbelt 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 120 Greenhill Road				10f. Zip Code 20770		10g. Citizen of What Country? United States
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Television Technician				16b. Kind of Business/Industry Service				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ernest Pisano Sr.				18. Mother's Name (First, Middle, Maiden Surname) Theresa DiGuardia						
	19a. Informant's Name/Relationship (Type, Print) Terry Goolsby				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Matapeake Drive Upper Marlboro Md. 20772						
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 2/14/96 Alexandria Virginia						
	21. Signature of Funeral Service Licensee Robert E. Evans Pres.		22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715								
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Small Cell Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Aortic valve replacement Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death 11 months		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic valve replacement				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Howard Tracer MD				29c. License number D41823		
	29d. Data signed (Month, Day, Year) 2/13/96				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Tracer, MD 8300 Corporate Drive Landover, Md. 20785						
State Registrar	31. Date filed (Month, Day, Year) FEB 21 1996				32. Registrar's Signature J. Anderson						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

03

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06521

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN PURVIS				2. Date of Death Month Day Year FEBRUARY 08, 1996				3. Time of Death 2:15PM	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 247-70-5842		6. Sex M F 2 M 2 F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) 4-27-43		9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Temple Hills				10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 3208 Dallas Drive				10f. Zip Code 20748		10g. Citizen of What Country? United States			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Delivery				16b. Kind of Business/Industry Self Employed	
	17. Father's Name (First, Middle, Last) Thomas James Purvis				18. Mother's Name (First, Middle, Maiden Surname) Leatha Mae Stevens					
	19a. Informant's Name/Relationship (Type, Print) Gloria Purvis - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3208 Dallas Drive, Temple Hills, Maryland 20748					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 2/17/1996		20c. Location - City or Town, State Clinton, Maryland			
	21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. Carcinoma Lung Due to (or as a consequence of):						Approximate Interval Between Onset and Death 6 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Pneumonia Due to (or as a consequence of):						6-7 Days		
		c. Due to (or as a consequence of):								
		d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
								24a. Was an autopsy performed? 1 Yes 2 No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 Medical Examiner 2 Certifying Physician		29b. Signature and title of certifier F. J. ...								
		29c. License number D42580				29d. Date signed (Month, Day, Year) 2-9-96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARMIST S. ... 5632 Annapolis Rd BLADENESBURG MD 20710.										
State Registrar	31. Date filed (Month, Day, Year) FEB 20 1996				32. Registrar's Signature John ...					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

96 06522

1. DECEDENT'S NAME (First, Middle, Last) <i>Raymond</i>		2. DATE OF DEATH MONTH <i>February</i> DAY <i>3</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>501A</i> M	
4. SOCIAL SECURITY NUMBER <i>577-74-3895</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>45</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>5-25-51</i>		8. BIRTHPLACE (State or Foreign Country) <i>Washington, DC</i>		9a. FACILITY NAME (If not institution, give street and number) <i>Southern Maryland Hospital</i>	
9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton, Md.</i>		9c. COUNTY OF DEATH <i>Prince George</i>		10a. STATE <i>DC</i>	
10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Washington</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1615 17th Street S.E. #306</i>		10f. ZIP CODE <i>20020</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Stock Clerk</i>	
16b. KIND OF BUSINESS/INDUSTRY <i>Gov't Agency</i>		17. FATHER'S NAME (First, Middle, Last) <i>Raymond Plowden, Sr.</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Renee Gross</i>	
19a. INFORMANT'S NAME (Type/Print) <i>Renee Plowden</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2417 Goodhope Rd. SE #1305 Wash, DC 20020</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harmony Memorial Park 2/17/96 Landover, Md.</i>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Clinton Layton</i>		22. NAME AND ADDRESS OF FACILITY <i>Robert G. Mason Funeral Home 1661 Good Hope Rd. S.E. Wash, DC 20020</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple injuries with complications</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>Jan 23, 1996</i>		28b. TIME OF INJURY <i>653A</i> M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>inmediate to vehicular impact</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>OLD MARLBORO PK., UPPER MARLBORO, Prince Georges, MD.</i>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Miguel P. Rodriguez MD</i>		29c. LICENSE NUMBER <i>221230</i>		29d. DATE SIGNED (Month, Day, Year) <i>February 3, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Miguel P. Rodriguez MD, 5009 Rayburn Ct. Op. Sp. MD 20748</i>					
31. DATE FILED (Month, Day, Year) <i>FEB 20 1996</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 06523
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) DORIS C. POTTER		2. Date of Death Month 2 / Day 2 / Year 1996		3. Time of Death 10:25AM	
4a. Facility Name (If not institution, give street and number) Arcola Nursing 901 Arcola Avenue		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 048-38-8413		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.	
8. Date of Birth (Month, Day, Year) 12/15/1912		9. Birthplace (State or Foreign Country) Massachusetts			
Usual Residence of Decedent					
10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 901 Arcola Avenue		10f. Zip Code 20902	
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 4 years	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher		16b. Kind of Business/Industry Public School System		17. Father's Name (First, Middle, Last) Edwin Claflin	
18. Mother's Name (First, Middle, Maiden Surname) Edith Upham		19a. Informant's Name/Relationship (Type, Print) Sylvia Daniels Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 BlueRidge Ave. Silver Spring, MD. 20902	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Georgetown Med. Sch. 2/2/96		20c. Location - City or Town, State Washington, D.C.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Austin Royster Funeral Home 3605 14th St. N.W. Wash, DC. 20010			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>Acute myocardial infarction</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 2 hours
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number DO 9834		29d. Date signed (Month, Day, Year) 2/20/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD.					
31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 06524

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDITH L. PFEIFFER		2. DATE OF DEATH MONTH DAY YEAR February 15, 1996		3. TIME OF DEATH 12:45 P M	
4. SOCIAL SECURITY NUMBER 213-74-2669		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Jun 1, 1904		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT					
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 212 Spring Street		10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KING OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Stanley C. Llewellyn		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian (Wilkenson)			
19a. INFORMANT'S NAME (Type/Print) John R. Pfeiffer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Moran Avenue, Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park 02/17		20c. LOCATION — City or Town, State Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli		22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death 1 HR.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER R. J. Barrera		29c. LICENSE NUMBER D14865		29d. DATE SIGNED (Month, Day, Year) FEB. 16, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. R. Barrera Memorial Hospital Medical Building Cumberland, MD. 21502					
31. DATE FILED (Month, Day, Year) FEB 16 1996		32. REGISTRAR'S SIGNATURE J. H. [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06525

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald LeRoy Poole				2. Date of Death Month February Day 20, 1996 Year		3. Time of Death 11:00pm		
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles		
Funeral Director	5. Social Security Number 214-30-0257		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 2, 1934	9. Birthplace (State or Foreign Country) VA	
	Usual Residence of Decedent								
10a. State FL		10b. County Manatee		10c. City, Town or Location Ellenton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 4119 Long Lake Way				10f. Zip Code 34222		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer			16b. Kind of Business/Industry Police Officer		
17. Father's Name (First, Middle, Last) Reginald LeRoy Poole				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Loretta Campbell Poole					
19a. Informant's Name/Relationship (Type, Print) Catherine Ann Poole				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4119 Long Lake Way Ellenton, FL 34222					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Rest Cem.		20c. Location - City or Town, State LaPlata, MD		20d. Date 2/23/96		
21. Signature of Funeral Service Licensee <i>[Signature]</i> MO0174				22. Name and Address of Facility P.O. Box 567 LaPlata, MD 20646					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Terminal lung cancer</i> Due to (or as a consequence of): b. <i>cardiac respiratory arrest</i> Due to (or as a consequence of): c. <i>chronic obstructive pulmonary disease</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>1 year</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 2-20-96		28b. Time of Injury 11 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Physicians Mem. Hospital</i>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Loheed Akthar</i>		29c. License number D31675		29d. Date signed (Month, Day, Year) 2-21-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waheed Akthar, MD White Plains Medical Center P.O. Box 1737 White Plains, MD 20695									
31. Date filed (Month, Day, Year) FEB 23 1996				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

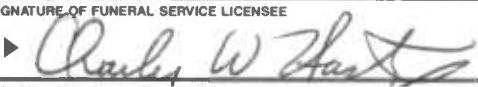
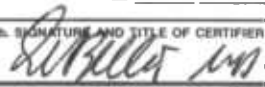
Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 06526

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE W. QUILLEN				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11, 1996		3. TIME OF DEATH 600 M	
4. SOCIAL SECURITY NUMBER 217-30-8294		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 14, 1912	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE MARYLAND		10b. COUNTY WORCESTER	
10c. CITY, TOWN OR LOCATION BISHOPVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11648 ST. MARTIN'S NECK ROAD	
10f. ZIP CODE 21813				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER				16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION			
17. FATHER'S NAME (First, Middle, Last) PETER QUILLEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOLLIE LEWIS			
19a. INFORMANT'S NAME (Type/Print) LORETTA S. DONOWAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12307 GODFREY BUNTING RD., BISHOPVILLE, MD. 21813			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BISHOPVILLE CEMETERY 2/14/96		20c. LOCATION — City or Town, State BISHOPVILLE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRACEREBRAL HEMORRHAGE							
b. HYPERTENSION							
c. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DL8587		29d. DATE SIGNED (Month, Day, Year) 2/11/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOB KUSERSINS DR. SALISBURY MD 21801 Edwin H. Bellis M.D.							
31. DATE FILED (Month, Day, Year) FEB 14 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06527

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH CECELIA QUADE

2. Date of Death

February 22 1996

3. Time of Death

5:00 P.M.

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

214-60-3013

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3705 Three Notch Road

10f. Zip Code

20659

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th grade

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Sidney McKinley

Connelly

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Violet Cusic

19e. Informant's Name/Relationship (Type, Print)

Angela Graves

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Three Notch Rd., Mechanicsville, Maryland 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Charles Memorial Gardens

Date

2/26/96

20c. Location - City or Town, State

Leonardtwn, Maryland

21. Signature of Funeral Service Licensee

Michael L. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Occult Malignancy
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. Allen

29c. License number

D25230

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. DAVID C. ALLEN

LEONARDTOWN, MD. 20650

State
Registrar

31. Date filed (Month, Day, Year)

FEB 26 1996

32. Registrar's Signature

John A. Anderson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06528

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PERNETHA S. ROSS		2. Date of Death Month Day Year FEBRUARY 21, 1996		3. Time of Death 09:50 AM
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 243-50-5572	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Mar. 31 1936		9. Birthplace (State or Foreign Country) NORTH CAROLINA		
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County DORCHESTER		10c. City, Town or Location CAMBRIDGE
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 918 Mace's Lane		10f. Zip Code 21613		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EDUCATOR		16b. Kind of Business/Industry DORCHESTER CO
	17. Father's Name (First, Middle, Last) Frank Smith		18. Mother's Name (First, Middle, Maiden Surname) Alma Chisolm		
	19a. Informant's Name/Relationship (Type, Print) Cembrye Ross		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1428 E. Capital St. N.E. Washington D.C.		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery		20c. Location - City or Town, State 2-24-96 Cambridge, Maryland
	21. Signature of Funeral Service Licensee Lewis H. Boardley		22. Name and Address of Facility L. H. Boardley Funeral Home 812 Hubbard St., Cambridge, Maryland		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pancytopenia Due to (or as a consequence of): Immunosuppression Due to (or as a consequence of): Liver Transplantation				Approximate Interval Between Onset and Death 2 weeks one month 2 1/2 months 2 1/2 months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Primary Biliary Cirrhosis Diabetes				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier L. H. Boardley MD		29c. License number 141742		29d. Date signed (Month, Day, Year) 2/21/96
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARREN R MARY GOON WOLFE ST BALT. MD 21287				
State Registrar	31. Date filed (Month, Day, Year) FEB 23 1996		32. Registrar's Signature Johanna Anderson-Randall		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

527 P. 2

2. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

3. The second part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

4. The third part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

5. The fourth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

6. The fifth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

7. The sixth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

8. The seventh part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

9. The eighth part of the paper is devoted to a discussion of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06529

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Manola Frances Robinson

2. Date of Death

February 19, 1996

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

Mallard Bay Nursing Home

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

214-28-8616

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 5, 1899

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Crocheron

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

Phillips Gunning Club Road

10f. Zip Code

21627

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Benjamin Franklin Sullender

18. Mother's Name (First, Middle, Maiden Surname)

Etta Todd

19a. Informant's Name/Relationship (Type, Print)

Roucelle N. Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1476 Phillips Gunning Club Rd. Crocheron, Md 21627

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dorchester Memorial Park

Date

2/22

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.
700 Locust Street Cambridge, Maryland 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Arteriosclerotic Cardio-vascular DiseaseApproximate
Interval Between
Onset and Death3 yearsSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D14349

29d. Date signed (Month, Day, Year)

2/22/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eyup Tanman, M.D. 15 Franklin Street Cambridge, Maryland 21613

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

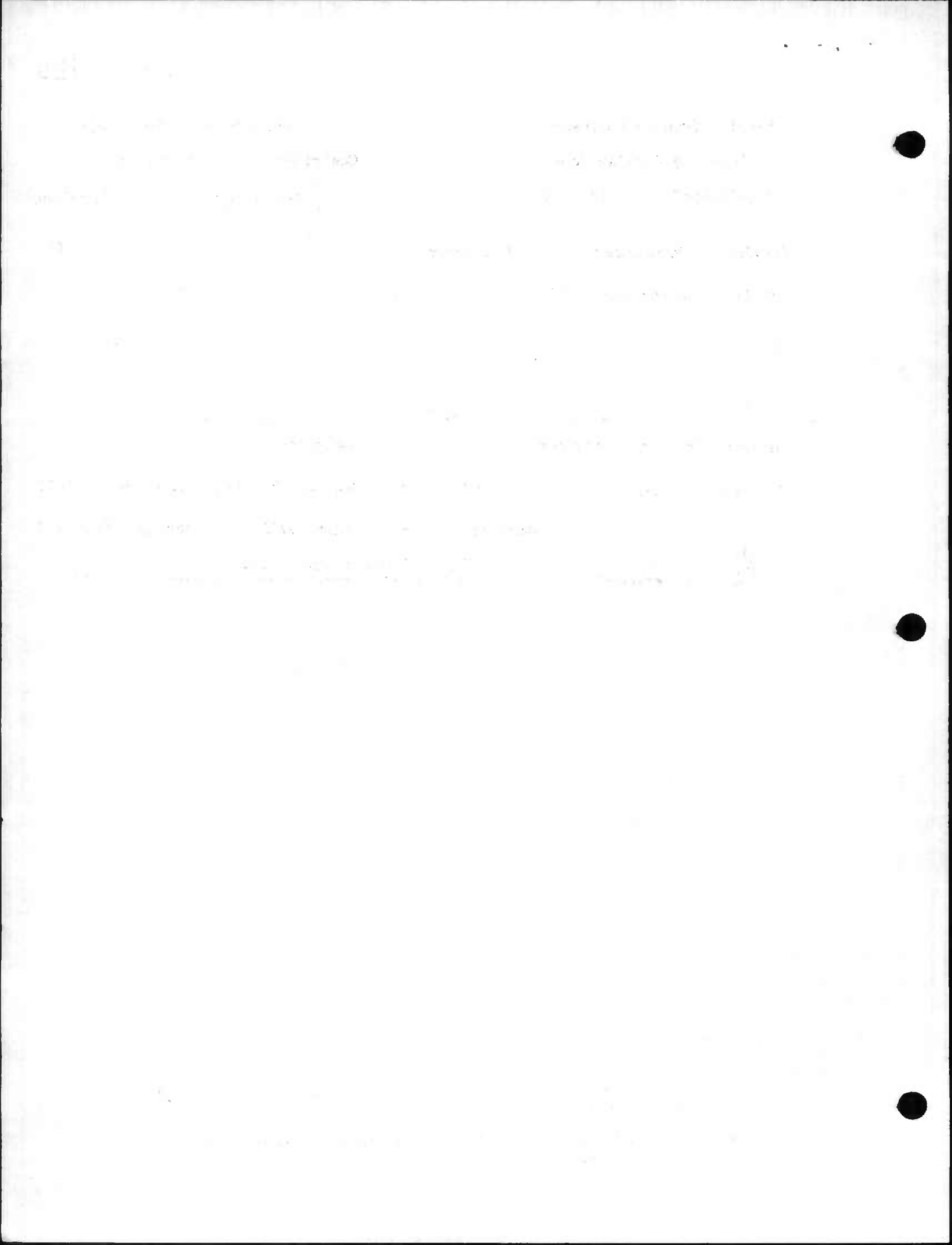
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) F. Hall Robertson				2. DATE OF DEATH MONTH DAY YEAR Feb 21 1996		3. TIME OF DEATH 11:55am M	
4. SOCIAL SECURITY NUMBER 219-36-1447		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 16 1908	
9a. FACILITY NAME (If not institution, give street and number) 717 Rising Sun Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Colora		9c. COUNTY OF DEATH Cecil		8. BIRTHPLACE (State or Foreign Country) Virginia	
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Colora		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 717 Rising Sun Rd.		10f. ZIP CODE 21917		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
17. FATHER'S NAME (First, Middle, Last) Tyre Robertson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Richardson			
19a. INFORMANT'S NAME (Type/Print) Nancy Pyle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Rising Sun Rd Colora MD 21917			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Brookview Cemetery Feb 24 1996 Rising Sun MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Gordie</i>				22. NAME AND ADDRESS OF FACILITY R. T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>CHF / Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 years 3 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D44373		29d. DATE SIGNED (Month, Day, Year) 2/21/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 101 Colonial Way Suite A Rising Sun, MD 21911							
31. DATE FILED (Month, Day, Year) FEB 23 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR
STATE
REGISTER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) John Joseph Rader				2. DATE OF DEATH MONTH DAY YEAR February 16, 1996				3. TIME OF DEATH 9:05 P. M.					
4. SOCIAL SECURITY NUMBER 578-62-8246				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 31, 1936		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) 21453 Morris Drive				9b. CITY, TOWN OR LOCATION OF DEATH Lexington Park				9c. COUNTY OF DEATH St. Mary's					
10a. STATE Maryland				10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Lexington Park				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 21453 Morris Drive				10f. ZIP CODE 20653				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) ----- College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A									
17. FATHER'S NAME (First, Middle, Last) Frank J. Rader				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna M. Hutchinson									
19a. INFORMANT'S NAME (Type/Print) Frances R. Marshall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 199, Tall Timbers, Maryland 20690									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill 2/20/96		20c. LOCATION — City or Town, State Suitland, Maryland									
21. SIGNATURE OF JOURNAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> Edward N. Brinsfield, Jr. M00052		22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Down Syndrome / Alzheimer's disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Alzheimer's disease Down Syndrome PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease								Approximate interval between Onset and Death Birth to death with dementia					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25a. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25b. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David M. Federele</i> David M. Federele, M.D.				29c. LICENSE NUMBER DB9198		29d. DATE SIGNED (Month, Day, Year) 2/14/96							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David M. Federele, M.D. 600 Moakley Street, Leonardtown, Maryland 20650													
31. DATE FILED (Month, Day, Year) FEB 20 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodall</i>											

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06532

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARL J. ROSAPEPE, SR.				2. Date of Death Month Day Year FEBRUARY 18, 1996		3. Time of Death 10:00 AM	
	4a. Facility Name (if not institution, give street and number) 11503 Alma Street				4b. City, Town, or Location of Death Wheaton		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 280-18-8285	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 7, 1919	9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery	
To Be Completed by Funeral Director	10c. City, Town or Location Wheaton				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 11503 Alma Street				10f. Zip Code 20902		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 5+		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Department of State			
	17. Father's Name (First, Middle, Last) Attilio Rosapepe				18. Mother's Name (First, Middle, Maiden Summa) Riva Shirkes			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Catherine M. Rosapepe				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11503 Alma Street Wheaton, Maryland 20902			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland		20d. Date 2/22/96	
	21. Signature of Funeral Service Licensee Robert E. Ramsey				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., West Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Carcinoma of Prostate</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death Years							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstruction pulmonary disease</i> <i>Hypertension</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>James M. ... MD</i>				29c. License number D03792		29d. Date signed (Month, Day, Year) 2/19/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRVING J. OBER, MD 10361 GA. AVE, SILVER SPRING, MD 20902								
31. Date filed (Month, Day, Year) FEB 21 1996				32. Registrar's Signature <i>John Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 06533

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie Rosenblatt				2. DATE OF DEATH MONTH DAY YEAR Feb 12, 1996		3. TIME OF DEATH 1:45 P M	
4. SOCIAL SECURITY NUMBER 071-28-0553		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 4, 1908	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8319 Snug Hill Lane				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Morris Leizeron				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fanny Steinberg			
19a. INFORMANT'S NAME (Type/Print) Myrna Malakoff/ Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8319 Snug Hill Lane Potomac, MD 20854			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Riverside Cem. True Fellow 2/13		20c. LOCATION — City or Town, State Riverside, NJ		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Obstructive Pulmonary Disease</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) Feb 12, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9707 Medical Center Dr #310 Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06534

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD RAYMOND REED				2. Date of Death Month February Day 3 Year 1996		3. Time of Death 7:00 PM	
	4a. Facility Name (If not institution, give street and number) 14 J Parkway Road				4b. City, Town, or Location of Death Greenbelt		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 523-36-6511		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 17, 1933	
	9. Birthplace (State or Foreign Country) Wyoming		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Greenbelt	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14 J Parkway Road		10f. Zip Code 20770		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1951-55		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Technician		16b. Kind of Business/Industry Computers			
	17. Father's Name (First, Middle, Last) Owen H. Reed				18. Mother's Name (First, Middle, Maiden Surname) Grace M. Evert			
	19a. Informant's Name/Relationship (Type, Print) William Reed (nephew)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13816 Poplar Tree Rd., Chantilly, VA 22021			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fairfax Crematory		20c. Location - City or Town, State 2-9-96 Fairfax, VA			
	21. Signature of Funeral Service Licensee <i>Christina Brezler</i>				22. Name and Address of Facility Everly Funeral Home 10565 Main St Fairfax, VA 22030			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Generalized Atherosclerotic Cardio-vascular Disease years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema, chronic anemia							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>J. Berger MD</i>				29c. License number D25925		29d. Date signed (Month, Day, Year) February 5, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN AVE, Bethesda, Md 20814							
	31. Date filed (Month, Day, Year) FEB 20 1996				32. Registrar's Signature <i>J. Steward Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06535

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILLIE CARMELA ROMANO				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 14, 1996		3. TIME OF DEATH 1:48 AM	
4. SOCIAL SECURITY NUMBER 218-80-6183		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1917	
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 904 A Martell Ct.				10f. ZIP CODE 21014		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Angelo (nmn) Russo				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria (nmn) Mangione			
19a. INFORMANT'S NAME (Type/Print) James G. Romano				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 A Martell Ct., Bel Air, Md. 21014			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park		20c. LOCATION — City or Town, State 2-17-96 Woodlawn, Md.		22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA, RIGHT LUNG Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): SEPSIS, STAPHYLOCOCCAL b. DUE TO (OR AS A CONSEQUENCE OF): INFECTED GORTOX AV GRAFT c. DUE TO (OR AS A CONSEQUENCE OF): d. CHRONIC RENAL FAILURE, ENDSTAGE ISCHEMIC CARDIOMYOPATHY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Nowakowski MD</i>				29c. LICENSE NUMBER D09086		29d. DATE SIGNED (Month, Day, Year) FEBRUARY 14, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDREW NOWAKOWSKI, MD, 125 N. MAIN ST, BELAIR, MD 21014							
31. DATE FILED (Month, Day, Year) FEB 15 1996				32. REGISTRAR'S SIGNATURE <i>John A. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06536

Certificate of Death

Reg. No.

3

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Ruth Ann Robins				2. Date of Death Month February Day 14 Year 1996		3. Time of Death 2205	
4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
5. Social Security Number 219-60-9775		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 17, 1955	
9. Birthplace (State or Foreign Country) Maryland							
10a. State MD		10b. County Harford		10c. City, Town or Location Perryman			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 428 Keene Drive				10f. Zip Code 21130		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager		16b. Kind of Business/Industry Toy Store	
17. Father's Name (First, Middle, Last) Forrest Edward Swearingen				18. Mother's Name (First, Middle, Maiden Surname) Saddieth Roseer			
19a. Informant's Name/Relationship (Type, Print) James J. Robins, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Keene Drive, Perryman, Maryland 21130			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc.		20c. Location - City or Town, State 02/16 West Chester, PA			
21. Signature of Funeral Service Licensee Madelyn Mitchell Shank				22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes stroke							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier My Benner physician				29c. License number D3693		29d. Date signed (Month, Day, Year) 2/14/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Benner Harford Memorial Hosp							
31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature John Andrew Randall					

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06537

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIANNA Rice						2. Date of Death Month February Day 14 Year 1996		3. Time of Death 2:07 PM	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital						4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 462-70-9118		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 1/3/1921		9. Birthplace (State or Foreign Country) Germany	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Darlington				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1658 Trappe Church Road				10f. Zip Code 21034		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Restaurant		
	17. Father's Name (First, Middle, Last) Johann Josef Bar				18. Mother's Name (First, Middle, Maiden Surname) Anna Barbara Linder					
	19a. Informant's Name/Relationship (Type, Print) Robert E. Rice (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Green Street, Havre de Grace, MD 21078					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BelAir Memorial Gardens		20c. Date 2/17		20d. Location - City or Town, State BelAir, Maryland			
	21. Signature of Funeral Service Licensee Kirsten Amy Ungleske				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Assystole Due to (or as a consequence of): d. Respiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jubel...		29c. License number D35832		29d. Date signed (Month, Day, Year) February 14, 1996				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Vivek Varma, M.D. 508 Girard Street, Havre de Grace, MD 21078										
31. Date filed (Month, Day, Year) FEB 15 1996										

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

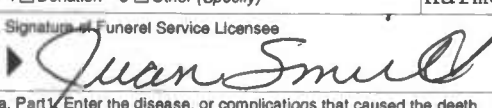
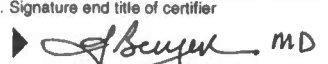

Amended #1, P. 8. 2/23/96

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06538

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT L. REID SR.		2. Date of Death Month February Day 17 Year 1996		3. Time of Death 1:40 Pm																
	4a. Facility Name (If not institution, give street and number) Prince George's Medical Center		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's																
Funeral Director	5. Social Security Number 579-099620	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.																
	8. Date of Birth (Month, Day, Year) 8/14/14		9. Birthplace (State or Foreign Country) Lancaster, SC																		
To Be Completed by Funeral Director	10a. State DC		10b. County N/A		10c. City, Town or Location Washington																
	10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No																				
	10e. Street and Number 2905 25th Street NE		10f. Zip Code 20018		10g. Citizen of What Country? USA																
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:																
	14. Race - American Indian, Black, White, etc. Specify: Black																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Grade College (1-4 or 5+) None		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-Employed		16b. Kind of Business/Industry Private																
	17. Father's Name (First, Middle, Last) Jim Reid		18. Mother's Name (First, Middle, Maiden Surname) Nannie Cunningham																		
	19a. Informant's Name/Relationship (Type, Print) Eric Reid		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 24th St NE, DC 20018																		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, Md.																
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John T. Rhines Co., Inc. 3030 12th St NE, DC 20017																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. Acute Cor Pulmonale</td> <td>Approximate Interval Between Onset and Death hours</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Cor Pulmonale</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c. Chronic Obstructive Lung Disease</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="3">d.</td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)	e. Acute Cor Pulmonale	Approximate Interval Between Onset and Death hours	Due to (or as a consequence of):		b. Cor Pulmonale	years	Due to (or as a consequence of):		Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Chronic Obstructive Lung Disease	years	Due to (or as a consequence of):		d.		
Immediate Cause (Final disease or condition resulting in death)	e. Acute Cor Pulmonale	Approximate Interval Between Onset and Death hours																			
	Due to (or as a consequence of):																				
	b. Cor Pulmonale	years																			
	Due to (or as a consequence of):																				
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Chronic Obstructive Lung Disease	years																			
	Due to (or as a consequence of):																				
d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Diabetes Mellitus insulin-dependent																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined																					
28a. Date of Injury (Month, Day, Year)																					
28b. Time of Injury M																					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
28d. Describe how injury occurred																					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																					
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier  MD																					
29c. License number D25925																					
29d. Date signed (Month, Day, Year) February 15, 1996																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. BERGER #205, 7720 Wisconsin Ave Bethesda Md 20814																					
31. Date filed (Month, Day, Year) FEB 23 1996																					
32. Registrar's Signature 																					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06539

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>IRMA G. ROBB</u>				2. Date of Death Month <u>FEB.</u> Day <u>10</u> Year <u>1996</u>				3. Time of Death <u>6:30 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Washington Adventist Hospital</u>				4b. City, Town, or Location of Death <u>Takoma Park</u>				4c. County of Death <u>Montgomery</u>	
Funeral Director	5. Social Security Number <u>004-16-8476</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>10/25/1908</u>		9. Birthplace (State or Foreign Country) <u>New Jersey</u>	
	Usual Residence of Decedent				10e. State <u>Maryland</u>				10b. County <u>Montgomery</u>	
To Be Completed by Funeral Director	10c. City, Town or Location <u>Silver Spring</u>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number <u>3314 Chiswick Court</u>				10f. Zip Code <u>20906</u>				10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+) <u>5+</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Teacher/Principal</u>				16b. Kind of Business/Industry <u>Public school system</u>	
	17. Father's Name (First, Middle, Last) <u>Raymond Robb</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Virginia Dane Robb</u>					
	19a. Informant's Name/Relationship (Type, Print) <u>Florence Dutcher</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3314 Chiswick Court, Silver Spring, MD. 20906</u>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Georgetown Medical</u>		20c. Date <u>2/10/96</u>		20d. Location - City or Town, State <u>Washington, D.C.</u>			
	21. Signature of Funeral Service Licensee <u>Tony A. Austin</u>				22. Name and Address of Facility <u>Austin Royster Funeral Home</u> <u>3605 14th St. N.W., Wash, DC 20010</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <u>HYPO TENSION AND BRADYCARDIA</u> Due to (or as a consequence of): b. <u>PULMONARY EDEMA</u> Due to (or as a consequence of): c. <u>HEART FAILURE</u> Due to (or as a consequence of): d. <u>AORTIC VALVE DISEASE</u>				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CORONARY ARTERY DISEASE</u> <u>UREMIA</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Tony A. Austin</u>				29c. License number <u>18551 D.</u>		
29d. Date signed (Month, Day, Year) <u>12 FEB. 1996</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SAMIR NEIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD, 20912</u>						
31. Date filed (Month, Day, Year) <u>FEB 21 1996</u>				32. Registrar's Signature <u>John D. ...</u>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06540

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vivian Ryan		2. Date of Death Month February Day 17 Year 1996		3. Time of Death 12:07 AM
	4a. Facility Name (If not Institution, give street and number) Gladys Spellman Nursing Care Center		4b. City, Town, or Location of Death Cheverly, MD		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 083-20-4264	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 21, 1923		9. Birthplace (State or Foreign Country) Kent Island, MD		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Prince Georges
	10c. City, Town or Location Riverdale		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 6149 64th Ave. #4		10f. Zip Code 20737		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Collage (1-4 or 5+) Collage		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic
	16b. Kind of Business/Industry PRIVATE		17. Father's Name (First, Middle, Last) Albert Bordley		18. Mother's Name (First, Middle, Maiden Surname) Julia E. Jones
	19a. Informant's Name/Relationship (Type, Print) Joan F. Evans / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6822 Buchanan St. Hyattsville, MD 20784		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Batt's Neck Cemetery		20c. Location - City or Town, State Stevensville, MD
	21. Signature of Funeral Service Licensee J.P. Marshall		22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W., Wash., DC 20011		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. SEPTICEMIA Due to (or as a consequence of): b. RESPIRATORY FAILURE Due to (or as a consequence of): c. ANOXIC ENCEPHALOPATHY Due to (or as a consequence of): d.				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN, DM; She was DAR.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier J.P. Marshall		29c. License number D-34525		29d. Date signed (Month, Day, Year) 02-18-96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) S-J-Rao, MD; 4000-Mitchellville Road; #220; Bowie-MD-20716					
31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature John Andrew Ruckel			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

01

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the theoretical and practical significance of the findings, and the limitations of the study.

5. The fifth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the overall results.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a bibliography. It includes a list of the books, articles, and other sources used in the study.

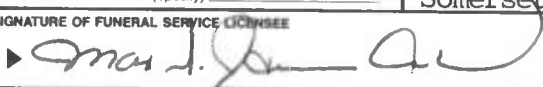
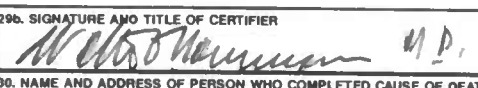
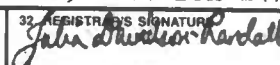
9. The ninth part of the report is a list of tables. It includes a list of the tables used in the study.

10. The tenth part of the report is a list of figures. It includes a list of the figures used in the study.

96 06541

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Myrtle I. Sleasman				2. DATE OF DEATH MONTH DAY YEAR 02 28 96		3. TIME OF DEATH 4:00 A M	
4. SOCIAL SECURITY NUMBER 175-20-1587		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/05/05	
8. BIRTHPLACE (State or Foreign Country) MD		9a. FACILITY NAME (If not institution, give street and number) 623 E. High St.		9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
10a. STATE MD				10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 623 E. High St.		10f. ZIP CODE 21550	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James H. Umbel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Zaloma Friend			
19a. INFORMANT'S NAME (Type/Print) Annetta Grove				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Friendsville, MD 21531			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Somerset Memorial Park 3/1		20c. LOCATION — City or Town, State Somerset, PA		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Humbert Funeral Home, Inc. Confluence, PA 15424		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, non insulin dependent Tobacco smoking did not contribute to the cause of death						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) personal care home	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER D25759		29d. DATE SIGNED (Month, Day, Year) February 28, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter K. Naumann, M.D., P.O. Box 247, Accident, MD 21520							
31. DATE FILED (Month, Day, Year) MAR 06 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1130



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06542

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY ELIZABETH SPENCER				2. Date of Death Month January Day 11 Year 1996				3. Time of Death 0520			
	4a. Facility Name (If not institution, give street and number) William Hill Health Care Center				4b. City, Town, or Location of Death Cambridge				4c. County of Death Dorchester			
Funeral Director	5. Social Security Number 217-05-7584		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
	8. Date of Birth (Month, Day, Year) Feb. 18 1915		9. Birthplace (State or Foreign Country) Delaware		Usual Residence of Decedent		10e. State Maryland		10b. County Dorchester			
To Be Completed by Funeral Director	10c. City, Town or Location Cambridge		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 525 Glenburn Ave.		10f. Zip Code 21613		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) food service,		16b. Kind of Business/Industry restaurant, hospital					
	17. Father's Name (First, Middle, Last) Thomas Cordrey				18. Mother's Name (First, Middle, Maiden Surname) Minnie Mills							
	19a. Informant's Name/Relationship (Type, Print) Mrs. Betty McAllister,				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Hambrook Blvd., Cambridge MD 21613							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery		Date 1/13		20c. Location - City or Town, State Oak Grove Delaware					
	21. Signature of Funeral Service Licensee ► Kenneth R. Moore Jr				22. Name and Address of Facility Thomas Funeral Home 700 Locust St. Cambridge MD 21613							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) e. <u>Respiratory Failure</u> Due to (or as a consequence of): <u>COPD</u> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										<u>2 DAYS</u> <u>15 years</u>	
	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. <u>osteoporosis</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined										28a. Date of Injury (Month, Day Year)		
28b. Time of Injury M										28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred										28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier ► M. J. Hall		
29c. License number D26388										29d. Date signed (Month, Day, Year) 02-16-1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael Fadden MD 302 Collins Hurlock Md 21643												
31. Date filed (Month, Day, Year) FEB 16 1996										32. Registrar's Signature John Davidson Randall		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06543

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTHER MAY SLOAN				2. Date of Death Month February Day 17 Year 1996		3. Time of Death 10:00 am																											
	4a. Facility Name (If not institution, give street and number) 5640 Mt. Holly Rd.				4b. City, Town, or Location of Death East New Market		4c. County of Death Dorchester																											
Funeral Director	5. Social Security Number 213-40-6301		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) May 12 1904																											
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Dorchester		10c. City, Town or Location East New Market																											
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5640 Mt. Holly Road		10f. Zip Code 21631		10g. Citizen of What Country? U.S.A.																											
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) teacher-homemaker		16b. Kind of Business/Industry public schools																													
	17. Father's Name (First, Middle, Last) Melvin Stalker				18. Mother's Name (First, Middle, Maiden Surname) Eva Jane Hoffman																													
	19a. Informant's Name/Relationship (Type, Print) James E. Sloan				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5640 Mt. Holly Rd., East New Market, MD 21631																													
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory 2/19		20c. Location - City or Town, State Salisbury Maryland																													
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home 700 Locust St. Cambridge MD 21613																													
	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Alzheimer's - End stage</td> <td rowspan="4">Approximate Interval Between Onset and Death 14 yrs</td> </tr> <tr> <td>b.</td> <td>Malnutrition</td> <td>2 1/2 yrs</td> </tr> <tr> <td>c.</td> <td>Chronic Dehydration</td> <td>2 yrs</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Alzheimer's - End stage	Approximate Interval Between Onset and Death 14 yrs	b.	Malnutrition	2 1/2 yrs	c.	Chronic Dehydration	2 yrs	d.															
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d.																																		
<table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature 																																

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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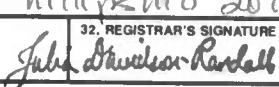
Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06544

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Edna E. Saunders				2. DATE OF DEATH MONTH DAY YEAR Feb. 16 1996		3. TIME OF DEATH 10:10 AM	
4. SOCIAL SECURITY NUMBER 211-20-3296		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-26-16	
9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEASED							
10a. STATE PA		10b. COUNTY Chester		10c. CITY, TOWN OR LOCATION Nottingham		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 41 Nottingham Drive				10f. ZIP CODE 19362		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) John H. Hill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosie McMillan			
19a. INFORMANT'S NAME (Type/Print) Eldon R. Saunders				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Nottingham Dr. Nottingham, PA 19362			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) A. A. Ferris & Co. 2-17-96 West Chester, PA		20c. LOCATION — City or Town, State PA		20d. DATE 2-17-96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward L. Collins Funeral Home, Inc. 86 Pine St. Oxford, PA 19363			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Renal Failure				Approximate Interval Between Onset and Death 2 YRS	
		b. Diabetes Mellitus				2 YRS +	
		c. Capillary HTN failure				2 Wks	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 209482		29d. DATE SIGNED (Month, Day, Year) 2/17/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Malcolm D. Phillips MD 2015 Shunesville Rd DARTINGTON MD 21034-0900							
31. DATE FILED (Month, Day, Year) FEB 21 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06545

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Francis William Stubbs, Sr.				2. DATE OF DEATH MONTH DAY YEAR February 17 1996		3. TIME OF DEATH 0840P	
4. SOCIAL SECURITY NUMBER 218-32-8139		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 14, 1937	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not Institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Chesapeake City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 100 Grason Avenue, Apt. 201				10f. ZIP CODE 21915		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance		15b. KIND OF BUSINESS/INDUSTRY Apartment Communities Corp.			
17. FATHER'S NAME (First, Middle, Last) Grason Ray Stubbs, Sr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Rebecca Meeham			
19a. INFORMANT'S NAME (Type/Print) Francis W. Stubbs, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Abbott Drive - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery 2020 1996		20c. LOCATION — City or Town, State Chesapeake City, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald S. Hicks				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. acute myocardial infarction 1D							
b. old myocardial infarction 3Y.							
c. ASCVD. 3Y.							
d. Diabetic melitus 3Y.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jui-chih Hsu MD				29c. LICENSE NUMBER D04823		29d. DATE SIGNED (Month, Day, Year) 2/18/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui-chih Hsu, MD 223 West main st, Elkton MD 21921							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

NAME Francis William Stubbs Sr. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 06546

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE THOMAS SMITH JR.				2. DATE OF DEATH MONTH DAY YEAR February 24 1996		3. TIME OF DEATH 1:30 A M	
4. SOCIAL SECURITY NUMBER 217-07-4785		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 15, 1915	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) V.A. Maryland Health Care System		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION Conowingo				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 20 Ratledge Lane	
10f. ZIP CODE 21918				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942 - 1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Five Years College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brick & Stone Mason		16b. KIND OF BUSINESS/INDUSTRY Unknown	
17. FATHER'S NAME (First, Middle, Last) George Thomas Smith, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Sampson			
19a. INFORMANT'S NAME (Type/Print) George T. Smith, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7107 Marsol, Houston, Texas 77083			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Company 2/26/96		20c. LOCATION — City or Town, State West Chester, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas M. Patterson, Sr.</i>				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas M. Patterson, Sr.</i>				29c. LICENSE NUMBER D 32395		29d. DATE SIGNED (Month, Day, Year) 2/24/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS FINUCAN, M.D., VA Medical Center, Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) FEB 26 1996				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94/104



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06547

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL LLOYD SIMPSON				2. Date of Death Month Day Year FEB 23 1996		3. Time of Death 2340 P	
	4a. Facility Name (If not institution, give street and number) MARYLAND RTE#231				4b. City, Town, or Location of Death WALDORF		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 217-68-7570	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 15, 1956		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 3361 Ryon Court				10f. Zip Code 20601		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steamfitter		16b. Kind of Business/Industry Local Union 602		
17. Father's Name (First, Middle, Last) Lloyd Simpson				18. Mother's Name (First, Middle, Maiden Sumame) Dolores McQueen				
19a. Informant's Name/Relationship (Type, Print) Connie A. Simpson-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3361 Ryon Ct., Waldorf, MD 20601				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Data 2-27-96		20c. Location - City or Town, State Clinton, MD		
21. Signature of Funeral Service Licensee <i>Benjamin Matthews</i> Benjamin Matthews M00658				22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Injuries</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 2 23 96		28b. Time of Injury 2342 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Fixed Object Driver of car impact with
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY				28f. Location (Street and Number or Rural Route Number, City or Town, State) MD RT 231 CHARLES CO MD		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>Marjorie Duffell</i>						
		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) FEBRUARY 24, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Registrar P. Korow MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) FEB 27 1996		32. Registrar's Signature <i>John Andrew Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 06548

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ottilia Emma Roache Schaffer				2. DATE OF DEATH MONTH DAY YEAR February 24, 1996				3. TIME OF DEATH 12:20 P.M.	
4. SOCIAL SECURITY NUMBER 215-62-9068		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) June 28, 1914		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtown			9c. COUNTY OF DEATH St. Mary's		
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Leonardtown			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 501 Bea Court				10f. ZIP CODE 20650		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) — — — —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY N/A				
17. FATHER'S NAME (First, Middle, Last) Daniel Rauch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Natalie Girsch					
19a. INFORMANT'S NAME (Type/Print) J. Barry Roache				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Old Route #5, Mechanicsville, Maryland 20659					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill		DATE 2/27/96		20c. LOCATION — City or Town, State Suitland, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinsfield, Jr.</i> M00052				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Aortic Aneurysm</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death Sec.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Boyd, M.D.</i>				29c. LICENSE NUMBER D14285			29d. DATE SIGNED (Month, Day, Year) 2-26-96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Boyd, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650									
31. DATE FILED (Month, Day, Year) FEB 27 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06549

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROY EDWIN STEVENS			2. Date of Death Month Day Year FEBRUARY 22, 1996		3. Time of Death 3:25 AM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL			4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
Funeral Director	5. Social Security Number 228-27-8230	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 16, 1966	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Carroll	10c. City, Town or Location Westminster			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 66 South Bishop Street			10f. Zip Code 21157		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Department Store	
	17. Father's Name (First, Middle, Last) Merle Eugene Stevens			18. Mother's Name (First, Middle, Maiden Surname) Barbara Ann Hicks			
	19a. Informant's Name/Relationship (Type, Print) Regina A. Eagle			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 66 S. Bishop St, Westminster, MD 21157			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) South Fork Cemetery		20c. Location - City or Town, State 2/25 Piney Creek, NC		
	21. Signature of Funeral Service Licensee <i>Sue A. Haherty-Hyatt</i>			22. Name and Address of Facility Myers Funeral Home 91 Willis Street, Westminster, MD 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMOTHORAX Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. RETROVIRAL INFECTION Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 DAYS 7 DAYS > 2 YEARS						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier <i>Dr. P. M. Year...</i>			29c. License number M6104		29d. Date signed (Month, Day, Year) February 22, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 N. CROWE ST, 7TH FLOOR - INT MED, BALTO, MD 21287						
31. Date filed (Month, Day, Year) FEB 26 1996			32. Registrar's Signature <i>John Davidson Randall</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06550

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Sawchuk, Neddie Vonick</i>				2. DATE OF DEATH MONTH <i>2</i> DAY <i>18</i> YEAR <i>96</i>		3. TIME OF DEATH <i>8:15 A M</i>	
4. SOCIAL SECURITY NUMBER <i>125-12-7506</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>79</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 23, 1916</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>12707 Hammonton Road</i>				10f. ZIP CODE <i>20904</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>executive secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Montgomery College</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Simeon Vonick</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Strashinskaya</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Henry Avery Sawchuk</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12707 Hammonton Rd., Silver Spring, Md. 20904</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Olivet Cemetery Feb. 24, 96</i>		20c. LOCATION — City or Town, State <i>Queens, New York</i>		20d. DATE <i>Feb. 24, 96</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>cardiomyopathy ischemic</i> <i>diabetes mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Rosen MD</i>				29c. LICENSE NUMBER <i>D 20400</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/18/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mark Rosen, Silver Spring, MD</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 21 1996</i>				32. REGISTRAR'S SIGNATURE <i>Johanna Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06551

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SADIE K. SINGER				2. Date of Death Month Day Year FEB 17 1996		3. Time of Death 0838		
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 577-10-9808		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 30, 1913		
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4710 BETHESDA AVENUE #1414		10f. Zip Code 20814		10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) LOUIS KLIVITZKY		18. Mother's Name (First, Middle, Maiden Surname) FREIDA LIPSHULTZ	
19a. Informant's Name/Relationship (Type, Print) MARCYNE KOLKER (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 GROSVENOR LANE #917 ROCKVILLE, MARYLAND 20852		20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID		20c. Location - City or Town, State 2-19-96 FALLS CHURCH, VIRGINIA	
21. Signature of Funeral Service Licensee <i>Frank A. Stone</i>		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Respiratory failure - ARDS Due to (or as a consequence of): f. Multisystem organ failure Due to (or as a consequence of): g. Ovarian Carcinoma		Approximate Interval Between Onset and Death 10d 10d 20d			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M	
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>David A. Holden M.D.</i>		29c. License number D47791		29d. Date signed (Month, Day, Year) FEB 17, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David A. Holden MD 809 Veirs Mill, Rockville, MD		31. Date filed (Month, Day, Year) FEB 22 1996		32. Registrar's Signature <i>John Davidson-Rodell</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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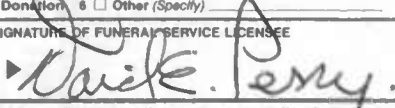

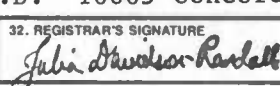
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96 06552

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John T. Sheehan				2. DATE OF DEATH MONTH DAY YEAR February 19, 1996				3. TIME OF DEATH 10:45 A M	
4. SOCIAL SECURITY NUMBER 129-14-5204		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 1, 1925		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) 14302 Arctic Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14302 Arctic Avenue				10f. ZIP CODE 20853		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Officer		16b. KIND OF BUSINESS/INDUSTRY Real Estate					
17. FATHER'S NAME (First, Middle, Last) John Joseph Sheehan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Cregan					
19a. INFORMANT'S NAME (Type/Print) Margaret A. Sheehan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14302 Arctic Avenue, Rockville, Maryland 20853					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery February 22, 1996				20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00803				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ESOPHAGEAL Cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED							
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29675		29d. DATE SIGNED (Month, Day, Year) February 20, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ralph V. Boccia, M.D. 10605 Concord Street, #300, Kensington, Maryland 20895									
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY JO SPARROW				2. Date of Death Month FEB. Day 13 Year 1996		3. Time of Death 3:00 PM		
	4a. Facility Name (If not Institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 216-30-2084		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 7, 1935		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13508 Grenoble Drive		10f. Zip Code 20853		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry United States Government					
17. Father's Name (First, Middle, Last) George O. Hollar				18. Mother's Name (First, Middle, Maiden Surname) Margaret A. Davis					
19a. Informant's Name/Relationship (Type, Print) Donald R. Sparrow				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13508 Grenoble Drive, Rockville, Maryland 20853					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State 2/16/96 Silver Spring, MD					
21. Signature of Funeral Service Licensee <i>Andrew J. Cole</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gun shot wound of head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. } Due to (or as a consequence of): c. } Due to (or as a consequence of): d. }		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 2-12-96		28b. Time of Injury 2200 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 13508 Grenoble Dr Silver Spring					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>							
		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEB. 14, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler		31. Date filed (Month, Day, Year) FEB 16 1996							
		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06554

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara L. Sickles		2. Date of Death Month Feb. Day 20 Year 1996		3. Time of Death 11:20 a.
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital		4b. City, Town, or Location of Death Rockville		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 186-30-3426	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 15, 1937		9. Birthplace (State or Foreign Country) Penn.		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Montgomery
	10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 343 N. Van Buren Street		10f. Zip Code 20850		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Operator		16b. Kind of Business/Industry Montg. Co. Schools		
	17. Father's Name (First, Middle, Last) Ocie Dankins		18. Mother's Name (First, Middle, Maiden Surname) Ethel Johnson		
	19a. Informant's Name/Relationship (Type, Print) Francine McCants (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 North Street, Rockville, MD 20850		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem. Park 2/26		20c. Location - City or Town, State Rockville, MD
	21. Signature of Funeral Service Licensee <i>George R. Anderson</i>		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) MASSIVE HEMOPTYSIS				MINUTES
	Due to (or as a consequence of):				
	NON-SMALL CELL LUNG CANCER				4 MONTHS
	Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 26608	29d. Date signed (Month, Day, Year) FEBRUARY 20, 1996
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) O'LEARY A. d'Nevecourt MD		ROCKVILLE, MD SHADY GROVE ADVENTIST HOSPITAL			
31. Date filed (Month, Day, Year) FEB 23 1996		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06555

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence Irene Spartin		2. Date of Death Month Feb. Day 6, Year 1996		3. Time of Death 7:06 P.M.	
	4a. Facility Name (If not institution, give street and number) Manor Care Potomac		4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 329-22-8570	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 17, 1906
	9. Birthplace (State or Foreign Country) Illinois					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Montgomery	
	10c. City, Town or Location Potomac		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 10714 Potomac Tennis Lane		10f. Zip Code 20854		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) R.N.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nurse		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) Nils Nelson		18. Mother's Name (First, Middle, Maiden Surname) Anna Johnson			
	19a. Informant's Name/Relationship (Type, Print) Joy S. Bowen (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8609 Ewing Dr., Bethesda, Md. 20817			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Feb. 8, 96 Alexandria, Va.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Avenue, NW Washington, DC 20007			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. Renal Failure Due to (or as a consequence of):		Approximate Interval Between Onset and Death 7 Days	
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Diabetic Coma Due to (or as a consequence of):		7 Days	
			c. Parkinsons Disease Due to (or as a consequence of):		5 Years	
			d. Hypertension Due to (or as a consequence of):		5 Years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined						
28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury 1 Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 						
29c. License number D 35792						
29d. Date signed (Month, Day, Year) February 7, 1996						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Swaroop G. Rao, MD 50 W. Edmonston Drive #504, Rockville, MD 20852						
31. Date filed (Month, Day, Year) FEB 21 1996						
32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06556

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yi-Chien Shen						2. Date of Death Month Day Year February 13, 1996		3. Time of Death 12:32 PM		
	4a. Facility Name (If not institution, give street and number) Suburban Hospital						4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 216-11-0208		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 5, 1920		9. Birthplace (State or Foreign Country) China		
	Usual Residence of Decedent										
10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Bethesda			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 4879 Battery Lane #1						10f. Zip Code 20814		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief of Auditing				16b. Kind of Business/Industry Bank			
17. Father's Name (First, Middle, Last) Zhi-Yu Shen						18. Mother's Name (First, Middle, Maiden Surname) Not Available					
19a. Informant's Name/Relationship (Type, Print) Yung-Yen Shen/son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Custer Road, Bethesda, Maryland 20817					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date Feb. 24, 1996		20c. Location - City or Town, State Bethesda, Maryland			
21. Signature of Funeral Service Licensee <i>Robert A. Pumphrey</i> M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. steroid dependent chronic obstructive pulmonary disease more than 10 yrs Due to (or as a consequence of): b. hypoxia Due to (or as a consequence of): c. bronchitis Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>H. Victor Chiang MD</i>				29c. License number D34969		29d. Date signed (Month, Day, Year) Feb. 13, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. Victor Chiang, MD 9707 Medical Center Dr. Suite 320 Rockville, MD 20850											
31. Date filed (Month, Day, Year) FEB 20 1996				32. Registrar's Signature <i>John Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

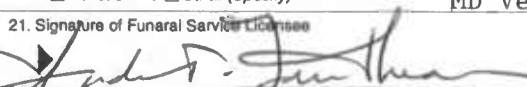
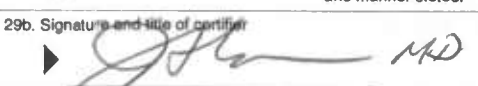
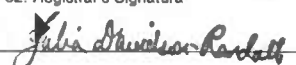
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06557

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHRISTOPHER THOMAS SAKADALES				2. Date of Death Month Day Year February 16, 1996		3. Time of Death 12:30 A.M.	
	4a. Facility Name (If not institution, give street and number) 199 Rollins Avenue, Apartment 301				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 86-22-5057		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1930	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 199 Rollins Avenue, Apartment 301		10f. Zip Code 20852		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1951-1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry Restaurant Business			
	17. Father's Name (First, Middle, Last) Thomas Steven Sakadales		18. Mother's Name (First, Middle, Maiden Surname) Anna Laura Calomeris		19a. Informant's Name/Relationship (Type, Print) Antoinette Sakadales-Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Biddle Road, Accokeek, Maryland 20607	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		20c. Location - City or Town, State 2-21-96 Cheltenham, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Congestive Heart Failure Due to (or as a consequence of): b. Ischemic Cardiomyopathy Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Transitional Cell Renal Cancer		Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number D41762		29d. Date signed (Month, Day, Year) 2/20/96	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN S. GLOER, MD 8300 Corporate Dr. Landover, MD 20785		31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature 			

96 06558

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Stewart				2. DATE OF DEATH MONTH DAY YEAR Feb. 10 1996		3. TIME OF DEATH 3:35 P. M.	
4. SOCIAL SECURITY NUMBER 577 84 3283		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 31, 1906	
8a. FACILITY NAME (If not institution, give street and number) Sacred Heart Home				8b. CITY, TOWN OR LOCATION OF DEATH Hyattsville		8c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 358 Scott Drive				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Unavailable				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Hamilton			
19a. INFORMANT'S NAME (Type/Print) James A. Richardson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 358 Scott Drive, Silver Spring, MD. 20904			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cem. 2/17/96		20c. LOCATION - City or Town, State Suitland, Maryland		20d. DATE 2/17/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrhythmia - Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Cardiac Arrhythmia - Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. Dehydration DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's, Dementia, Cerebrovascular Accident Hypertension							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER PHYSICIAN		29c. LICENSE NUMBER D40395		29d. DATE SIGNED (Month, Day, Year) Feb. 10, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Saraswathy Ramachandran, M.D., 7500 Greenway Center Dr., Greenbelt, MD. 20770							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06559

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul Sean				2. DATE OF DEATH MONTH DAY YEAR Feb. 16, 1996		3. TIME OF DEATH a M 8:55 a	
4. SOCIAL SECURITY NUMBER 578-01-5481		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 8, 1908		8. BIRTHPLACE (State or Foreign Country) Lithuania	
9a. FACILITY NAME (If not Institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 10110 New Hampshire Ave Apt 303				10f. ZIP CODE 20903		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Grocer		16b. KIND OF BUSINESS/INDUSTRY Retail			
17. FATHER'S NAME (First, Middle, Last) David Sean				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Yuter			
19a. INFORMANT'S NAME (Type/Print) Don Sean / Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14812 Waterway Dr. Rockville MD 20853			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Elesavetgrad Cemetery		20c. LOCATION — City or Town, State 2/18 Washington DC			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Cardiopulmonary Arrest							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Cardiovascular Disease							
DUE TO (OR AS A CONSEQUENCE OF):							
c. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 87650		29d. DATE SIGNED (Month, Day, Year) 2/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. SATO 1119 Rockville Pike #316 Rockville MD 20852							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH-1A Rev 1/89

96 06561

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Arthur Simon				2. DATE OF DEATH MONTH Feb DAY 18 YEAR 96		3. TIME OF DEATH 2:42 PM	
4. SOCIAL SECURITY NUMBER 141-20-4573		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 25, 1927	
8. BIRTHPLACE (State or Foreign Country) NEW JERSEY				9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MD.		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 10903 LOMBARDY RD.	
10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICAL ENGINEER		16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED	
17. FATHER'S NAME (First, Middle, Last) MICHAEL W. SIMON				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA STEIN			
19a. INFORMANT'S NAME (Type/Print) RACHEL SIMON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. LOCATION — City or Town, State 2/20 RIVERDALE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.W. Chambers MO0091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic heart Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John T. ...				29c. LICENSE NUMBER D08546		29d. DATE SIGNED (Month, Day, Year) Feb - 18 - 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. ... 8218 Wisconsin Ave Bethesda MD							
31. DATE FILED (Month, Day, Year) FEB 20 1996		32. REGISTRAR'S SIGNATURE John T. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06562

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank Albert STACHITAS				2. DATE OF DEATH MONTH DAY YEAR February 15 1996		3. TIME OF DEATH 4:00 a^m	
4. SOCIAL SECURITY NUMBER 182-16-6016		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 10, 1918	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Doctors Community Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Lanham-Seabrook	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland			
10b. COUNTY Prince George's				10c. CITY, TOWN OR LOCATION College Park			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 7322 Radcliffe Drive			
10f. ZIP CODE 20740				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Utility Contractor		16b. KIND OF BUSINESS/INDUSTRY self employed	
17. FATHER'S NAME (First, Middle, Last) Frank Stachitas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Kozlauskas			
19a. INFORMANT'S NAME (Type/Print) Aldona R. Stachitas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		DATE 2/16/1996		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER A21230		29d. DATE SIGNED (Month, Day, Year) February 15, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5009 Rayburn Ct, Camp Spr. Md 20748							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Walter Stockhausen				2. DATE OF DEATH MONTH DAY YEAR FEB 26 1996		3. TIME OF DEATH 10:00 PM	
4. SOCIAL SECURITY NUMBER 215-03-9675		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jul 7, 1905	
9a. FACILITY NAME (If not institution, give street and number) 205 St. Mark's Way Apt 521				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 205 St. Mark's Way Apt 521				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tool & Die		16b. KIND OF BUSINESS/INDUSTRY Bell Labs			
17. FATHER'S NAME (First, Middle, Last) Walter Stockhausen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Crawford			
19a. INFORMANT'S NAME (Type/Print) Jeane S. Stockhausen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Sunny Field Ct, 3-D, Hampstead, MD 21074			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 3/1		20c. LOCATION — City or Town, State Timonium, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S. Main St, Hampstead, MD 21074			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Harshey, MD</i>				29c. LICENSE NUMBER DD4934		29d. DATE SIGNED (Month, Day, Year) 2/28/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN S. HARSHEY, MD 752 WINCHESTER DR WESTMINSTER, MD 21157							
31. DATE FILED (Month, Day, Year) FEB 29 1996		32. REGISTRAR'S SIGNATURE <i>Julia Stocker Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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96 06564

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN COX STYCHE				2. DATE OF DEATH MONTH DAY YEAR Feb. 11, 1996		3. TIME OF DEATH 6:52 PM M	
4. SOCIAL SECURITY NUMBER 213-36-2864		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/2/10	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 512 Lee Way		9b. CITY, TOWN OR LOCATION OF DEATH Bel Air	
9c. COUNTY OF DEATH Harford				10a. STATE MD		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Whitehall				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4823 Carea Road	
10f. ZIP CODE 21161				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Samuel H. Cox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Salina Evans			
19a. INFORMANT'S NAME (Type/Print) Doris S. Sweet				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11801 Manor Rd., Glen Arm, MD 21057			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Yorktowne Crematory 2/14/96 York, PA		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Harkins F.H. Inc, Delta, PA 17314			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Alzheimers disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Heart Thyrroidectomy 1st of intracranial tumor							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D27925		29d. DATE SIGNED (Month, Day, Year) 2/13/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David W. McClure, M.D., 1131 Bel Air Road, Fallston, MD, 21047							
31. DATE FILED (Month, Day, Year) FEB 14 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06565

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS STEVEN SAGI				2. Date of Death Month February Day 9 Year 1996		3. Time of Death 9:40AM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 105-10-0749		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 14, 1921	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent				10a. State Maryland		10b. County Harford	
To Be Completed by Funeral Director	10c. City, Town or Location Fallston				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1319 Old Fallston Road	
	10f. Zip Code 21047				10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-45				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pupil Personnel Worker		16b. Kind of Business/Industry Education	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Louis (nmn) Sagi				18. Mother's Name (First, Middle, Maiden Surname) Julia U/K Tobias			
	19a. Informant's Name/Relationship (Type, Print) Betty J. Sagi - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Old Fallston Rd., P.O. Box 367, Fallston, Md. 21047			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		20c. Location - City or Town, State 2/21/96 Arlington, Virginia	
	21. Signature of Funeral Service Licensee <i>Stephen R. Huggins</i>				22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Glioblastoma				Approximate Interval Between Onset and Death 2 mos.			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Kendall R Faulkner</i>			
To Be Completed by Physician/Medical Examiner	29c. License number D 25643				29d. Date signed (Month, Day, Year) 2/9/96			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KENDALL FAULKNER, 2300 DULANEY VALLEY RD., TOWSON, MD 21204				31. Date filed (Month, Day, Year) FEB 14 1996			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>John Davidson-Randall</i>				33. State Registrar DR. KENDALL FAULKNER, 2300 DULANEY VALLEY RD., TOWSON, MD 21204			

96 06566

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUDOLPH SWINSON				2. DATE OF DEATH MONTH FEBRUARY DAY 13 , YEAR 1996		3. TIME OF DEATH 6:10 P.M.	
4. SOCIAL SECURITY NUMBER 579-44-4688		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) JANUARY 2, 35	
8. BIRTHPLACE (State or Foreign Country) WASHINGTON D.C.				9a. FACILITY NAME (If not institution, give street and number) 4315 Delmar Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Temple Hills	
9c. COUNTY OF DEATH Prince Georges				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Temple Hills				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4315 Delmar Avenue	
10f. ZIP CODE 20748				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant		16b. KIND OF BUSINESS/INDUSTRY Government	
17. FATHER'S NAME (First, Middle, Last) Roland Swinson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Booker Swinson			
19a. INFORMANT'S NAME (Type/Print) Ruth Booker Swinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Delmar Avenue, Temple Hills, Maryland 20748			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LINCOLN MEMORIAL CEMETERY 2/20/96		20c. LOCATION — City or Town, State SUITLAND, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Johnson & Jenkins Inc. 716 Kennedy Street, N.W. D.C. 20011		23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → GASTRIC CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER Md D25647		29d. DATE SIGNED (Month, Day, Year) 2/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew J. Lee Jr MD 1160 Varnum St. NE, WASH., DC 20017							
31. DATE FILED (Month, Day, Year) FEB 23 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

2-2-77 11:00 AM 000 05 697

96 06567

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie N. Sellman				2. DATE OF DEATH MONTH 2 DAY 16 YEAR 96		3. TIME OF DEATH 7:15 PM	
4. SOCIAL SECURITY NUMBER 577-46-0333		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) 4-6-1910		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Allegis Health & Rehab Center				9b. CITY, TOWN OR LOCATION OF DEATH Kensington		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3000 McComas Avenue				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maid		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) George Cole				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Brown			
19a. INFORMANT'S NAME (Type/Print) George Sellman/Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7730 Greymont Street, Landover, MD 20785			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery 2/22		20c. LOCATION — City or Town, State Clinton, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY J. B. Jenkins Funeral Home 20785 7474 Landover Rd, Landover, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALZHEIMER'S DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION; PARKINSON'S DISEASE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D08944		29d. DATE SIGNED (Month, Day, Year) 2/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN C. SHARGEL, MD.				3720 FALLAGUT AVE. KENSINGTON, MD 20895			
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2



96 06568

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NELLIE JOSEPHINE SMITH				2. DATE OF DEATH MONTH DAY YEAR February 19, 1996		3. TIME OF DEATH 2:36 P M	
4. SOCIAL SECURITY NUMBER 220-03-6986		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun. 23, 1912	
9a. FACILITY NAME (If not institution, give street and number) LAUREL REGIONAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Suitland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3403 Claire Drive				10f. ZIP CODE 20746		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home maker		16b. KIND OF BUSINESS/INDUSTRY self			
17. FATHER'S NAME (First, Middle, Last) Robert L. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Bryan			
19a. INFORMANT'S NAME (Type/Print) Lawrence E. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7714 Elgar St., N. Springfield, VA 22151			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Washington Nat'l. Cem. 2/22		20c. LOCATION — City or Town, State Suitland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.P. Marshall</i>				22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland RD. Suitland, MD 20746			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Arhythmia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): urosepsis b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 15 min. 2-3 days.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Parry</i>				29c. LICENSE NUMBER D 42580.		29d. DATE SIGNED (Month, Day, Year) 2-20-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P.S. AUSLA 5632 ANNAPOLIS RD SUD #14 BLADENSBURG MD 20710							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06569

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA WEAVER SCATES

2. Date of Death
Month Day Year
FEBRUARY 16 1996
3. Time of Death
10:00 AMFuneral
Director

4a. Facility Name (If not Institution, give street and number)

3028 Traymore Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

411-52-1471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

August 29, 1935

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State
Maryland
10b. County
Prince George's
10c. City, Town or Location
Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3028 Traymore Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

P.G. Co. Public Schools

17. Father's Name (First, Middle, Last)

William Harrison Scates

18. Mother's Name (First, Middle, Maiden Surname)

Stella Folsom Steele

19a. Informant's Name/Relationship (Type, Print)

George Scates

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3539 South Wakefield Street Arlington, Va. 22206-1707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 2-18-96 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.
16000 Annapolis Road Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3+ yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Berger MD

29c. License number

D25925

29d. Date signed (Month, Day, Year)

February 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814.

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

96 06570

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) (Eva M. Sanford) SANFORD, EVA				2. DATE OF DEATH MONTH DAY YEAR February 14 1996		3. TIME OF DEATH 3:30 A M	
4. SOCIAL SECURITY NUMBER 578-40-8183		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 26, 1901	
8. BIRTHPLACE (State or Foreign Country) Maine				9. COUNTY OF DEATH Prince George's			
9a. FACILITY NAME (If not institution, give street and number) Magnolia Gardens Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Cheverly		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5707 Landover Road				10f. ZIP CODE 20784-1230		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16. KIND OF BUSINESS/INDUSTRY Internal Revenue Service			
17. FATHER'S NAME (First, Middle, Last) unavailable				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Burnett			
19a. INFORMANT'S NAME (Type/Print) Toni Lee Stephens				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5707 Landover Road, Cheverly, Maryland 20784-1230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Port Lincoln Cemetery 2/16/1996		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition, Debility Sacral decubitus Left trochanteric Decubitus						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		27. DATE OF INJURY (Month, Day, Year)		28. TIME OF INJURY M		29. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. DESCRIBE HOW INJURY OCCURRED		28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mary B Maloney M.D.				29c. LICENSE NUMBER D 07478		29d. DATE SIGNED (Month, Day, Year) 2/14/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary B Maloney M.D. 4814-71st Ave Hyattsville MD 20784							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE John Andrew Randall			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

96 06571

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annie Mae Milbourne Stewart				2. DATE OF DEATH MONTH DAY YEAR 02-19-1996		3. TIME OF DEATH Not Known	
4. SOCIAL SECURITY NUMBER 217-28-4181		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-07-1932	
8. BIRTHPLACE (State or Foreign Country) Westover, Md				9a. FACILITY NAME (If not institution, give street and number) 8791 Wedda Scott Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Westover	
9c. COUNTY OF DEATH Somerset				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Westover Maryland				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 8791 Wedda Scott Rd.	
10f. ZIP CODE 21871				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Food Processing	
17. FATHER'S NAME (First, Middle, Last) Ballard A. Milbourne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Marie Miles			
19a. INFORMANT'S NAME (Type/Print) Weldon E. Milbourne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 Benton Way, Gahanna Ohio 43230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) Cottage Grove Meth. Ch. 2/24/96 Westover, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Savage Funeral Home P.O. Bx. 46 New Church, Va. 23415			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. gun shot wound to the head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D10214		29d. DATE SIGNED (Month, Day, Year) 2-22-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Sterling / 320 W. Main St. Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06572

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Virginia E. Sutton				2. DATE OF DEATH MONTH 02 DAY 17 YEAR 96		3. TIME OF DEATH NOT KNOWN	
4. SOCIAL SECURITY NUMBER 214-36-5692		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS 05 DAYS 16	IF UNDER 24 HRS. HOURS 16 MIN. 1937	7. DATE OF BIRTH (Month, Day, Year) 05-16-1937	
9a. FACILITY NAME (If not institution, give street and number) McCready Memorial Hosptial				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 244 Somers Cove Apt.				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) Laborer		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seafood		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) James Edward Boone				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie E. Whittington			
19a. INFORMANT'S NAME (Type/Print) Sidney R. Sutton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 Somers Cove Apt. Crisfield, MD 21817			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) John Wesley Cemetery 2-24-96 Marion, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony E. Ward</i>				22. NAME AND ADDRESS OF FACILITY Anthony E. Ward Funeral Home 314 Cove St. Crisfield, MD 21817			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval between Onset and Death 1 day	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James R. Sterling, MD</i>				29c. LICENSE NUMBER D10214		29d. DATE SIGNED (Month, Day, Year) 8/20/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) James Sterling / 320 W. Main St. Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) FEB 21 1996		32. REGISTRAR'S SIGNATURE <i>John A. Hurd</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

51

1981 1583

96 06573

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERA L. SHIPLEY				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1996		3. TIME OF DEATH 21:41 M	
4. SOCIAL SECURITY NUMBER 220-40-2169		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 7, 1921	
8a. FACILITY NAME (If not Institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER Williams Road			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Inglewood Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura B. (Clingerman)			
19a. INFORMANT'S NAME (Type/Print) Leroy Shipley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Winifred Road; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Christian Cem 02/18		20c. LOCATION — City or Town, State Artemas, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Shock							
b. URINARY TRACT Infection							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William Lamm MD				29c. LICENSE NUMBER D 25406		29d. DATE SIGNED (Month, Day, Year) Feb 16, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. William Lamm, 47 Virginia Ave., Cumberland, Md 21502							
31. DATE FILED (Month, Day, Year) FEB 16 1996				32. REGISTRAR'S SIGNATURE John J. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

812.

96 06574

Amended Hs 10c, 10f; 2/20/96, D&H, Allegany County

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FLOYD OSCAR SHAW				2. DATE OF DEATH MONTH DAY YEAR FEB 11 1996		3. TIME OF DEATH 7:30 P M	
4. SOCIAL SECURITY NUMBER 215-16-4620		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 7, 1922	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MD		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland Oldtown				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 20305 Oldtown Road SE	
10f. ZIP CODE 21502 21555				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Proprietor		16b. KIND OF BUSINESS/INDUSTRY Shaw's Tavern	
17. FATHER'S NAME (First, Middle, Last) Robert L. Shaw				18. MOTHER'S NAME (First, Middle, Maiden Surname) Isabell (Wiland)			
19a. INFORMANT'S NAME (Type/Print) Arbutus L. Shaw				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20305 Oldtown Road SE; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Laurel Hill Cemetery 02/16		20c. LOCATION — City or Town, State Moscow, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio Pulmonary Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure b. DUE TO (OR AS A CONSEQUENCE OF): Squamous Cell Carcinoma of Lung c. DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Lung Disease d. Approximate Interval Between Onset and Death 1 Hour 4 Years 8 Months 4 Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Stenosis							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER DR. CROSSLAND				29c. LICENSE NUMBER D25296		29d. DATE SIGNED (Month, Day, Year) February 13, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CROSSLAND 938 NATIONAL HWY LAVALE MD 21502							
31. DATE FILED (Month, Day, Year) FEB 16 1996				32. REGISTRAR'S SIGNATURE John A. ...			

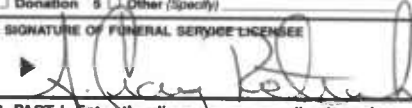
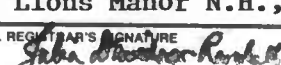
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

96 06575

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lee Shobe				2. DATE OF DEATH MONTH DAY YEAR Feb 20 1996		3. TIME OF DEATH 4:30 A M	
4. SOCIAL SECURITY NUMBER 236-20-9418		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 31 1915	
9a. FACILITY NAME (If not institution, give street and number) Lions Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE WV		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION New Creek		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER HC 75, Box 158				10f. ZIP CODE 26743		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY State of WV	
17. FATHER'S NAME (First, Middle, Last) Gabe Shobe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Elizabeth Simmons			
19a. INFORMANT'S NAME (Type/Print) Juanita M. Shobe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 75, Box 158 New Creek, WV 26743			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Davis Cemetery Feb 23 1996		20c. LOCATION — City or Town, State Antioch, WV		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced metastatic Prostatic Carcinoma Two yrs DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration pneumonia, S.P. Subdural hemorrhage, recurrent C.V.A.s							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER V.A. Ranjithan				29c. LICENSE NUMBER D19750		29d. DATE SIGNED (Month, Day, Year) Feb. 20, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V.A. Ranjithan, M.D., Lions Manor N.H., Seton Dr., Cumberland, MD. 21502							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06576

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRED LIVESAY SMITH				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1996		3. TIME OF DEATH 02:08	
4. SOCIAL SECURITY NUMBER 235-26-5749		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 7, 1923	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE WV		10b. COUNTY Hampshire		10c. CITY, TOWN OR LOCATION Green Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER P.O. Box 11				10f. ZIP CODE 26722		10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder		15b. KIND OF BUSINESS/INDUSTRY Railroad			
17. FATHER'S NAME (First, Middle, Last) Henry Harrison Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Aerie Elsie Gregg			
19a. INFORMANT'S NAME (Type/Print) Opal Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 11, Green Spring, WV 26722			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Glen Cemetery		20c. LOCATION — City or Town, State 2/5/96 Green Spring, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shaffer Funeral Home, INC.</i>				22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, INC. 230 E. Main St., Romney, WV 26757			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Metastasis with Coma Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Ca of lung with Metastasis COPD						Approximate Interval Between Onset and Death 1 year 2 year 4 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John N. Mehanna M.D.</i>				29c. LICENSE NUMBER D-17526		29d. DATE SIGNED (Month, Day, Year) February 2, 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John N. Mehanna, M.D. 902 Seton Drive, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE <i>John N. Mehanna</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


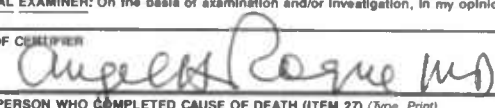
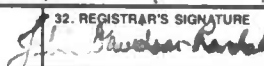
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06577

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RENA SHIRLEY SKIDMORE				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20 1996		3. TIME OF DEATH 8:45 A.M.	
4. SOCIAL SECURITY NUMBER 213-44-2104		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 10, 1938	
8. BIRTHPLACE (State or Foreign Country) F Maryland							
9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 193 S. Water Street				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeping		16b. KIND OF BUSINESS/INDUSTRY College	
17. FATHER'S NAME (First, Middle, Last) Jonas C. Skidmore				16. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Davis			
19a. INFORMANT'S NAME (Type/Print) Bertha Paletta				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1850 Ormand Street Frostburg, Maryland 21532			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Memorial Park 2/23/96		DATE 2/23/96		20c. LOCATION — City or Town, State Frostburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY FAILURE 3 weeks							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { MALIGNANT (L) PLEURAL EFFUSION 3 weeks							
c. METASTATIC CARCINOMA, (L) LUNG 4 MOS							
d. ENDOMETRIAL CARCINOMA 5 YRS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 13166		29d. DATE SIGNED (Month, Day, Year) FEBRUARY 21, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Rague 48 TARN TERRACE FROSTBURG MD. 21532							
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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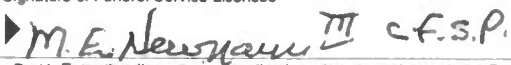


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06578

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN CONRAD Scheffler				2. Date of Death Month Feb. Day 19 Year 1996		3. Time of Death 8:00 PM	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 272-28-6021		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 6, 1933	
	9. Birthplace (State or Foreign Country) OHIO		10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 29363 4TH STREET		10f. Zip Code 21601		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FINANCE OFFICER		16b. Kind of Business/Industry NON-PROFIT ORGANIZATION			
	17. Father's Name (First, Middle, Last) FRANCIS LEWIS SCHEFFLER, SR.				18. Mother's Name (First, Middle, Maiden Surname) EMILY LOUISE KLOKER			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) NANCY S. SCHEFFLER/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29363 4TH ST., EASTON, MD 21601			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN MEM. PARK		Date 2-23		20c. Location - City or Town, State EASTON, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Trauma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. { Due to (or as a consequence of): c. { Due to (or as a consequence of): d. {				Approximate Interval Between Onset and Death Immediate			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 2-19-96		28b. Time of Injury App. 7 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred Hit by pick up truck				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) Chapel Rd. 0.6 mi East of Rt. 50							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number D24769				29d. Date signed (Month, Day, Year) 2-21-96			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) L. THOMAS DIVILIO, M.D., 404 MARVEL COURT, EASTON, MD 21601							
	31. Date filed (Month, Day, Year) FEB 22 1996				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

2. The second part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

3. The third part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

4. The fourth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

5. The fifth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

6. The sixth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

7. The seventh part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

8. The eighth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

9. The ninth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

10. The tenth part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS FURNISH Swing			2. Date of Death Month Day Year Feb. 20 1996		3. Time of Death 9:10 PM	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital at Easton			4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 214-34-8002	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 2, 1933	9. Birthplace (State or Foreign Country) IOWA
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD		10b. County TALBOT		10c. City, Town or Location TRAPPE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 3834 RUMSEY DRIVE			10f. Zip Code 21673		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry EDUCATION		
	17. Father's Name (First, Middle, Last) KENNETH CLAUDE FURNISH, SR.			18. Mother's Name (First, Middle, Maiden Surname) IRENE SIEGFRIED			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) J.M. SWING, JR. / HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3834 RUMSEY DRIVE, TRAPPE, MD 21673			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY		20c. Location - City or Town, State 2-22 SALISBURY, MD		
	21. Signature of Funeral Service Licensee JOHN R. MERCERON CFSO			22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gram Negative Sepsis with Shock Due to (or as a consequence of): b. Small Bowel Infarction Due to (or as a consequence of): c. Arteriosclerosis of Mesenteric Vessels Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 15 hrs 1 day Years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fractured Sacrum DUE TO OSTEOPOROSIS Recent total colectomy for Perforated Colon Acute Renal Failure / Acute Respiratory Distress Syndrome						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) November 15, 1995		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) stated.		28d. Describe how injury occurred Manipulation					
29b. Signature and title of certifier Wm Howard J.		29c. License number D08715		29d. Date signed (Month, Day, Year) February 21, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601							
31. Date filed (Month, Day, Year) FEB 22 1996		32. Registrar's Signature J. A. Swisher-Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.


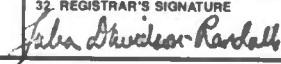
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06580

Amended # 18 & 19B, 2/29/96, LMG, Talbot
 1 - FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR RANDOLPH STRAWBERRY				2. DATE OF DEATH MONTH February DAY 15 , YEAR 1996		3. TIME OF DEATH 5:35 A M	
4. SOCIAL SECURITY NUMBER 220-28-0851		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 28, 1928	
8. BIRTHPLACE (State or Foreign Country) Dorchester				9a. FACILITY NAME (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEMS		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Dorchester	
10c. CITY, TOWN OR LOCATION Hurlock,				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 202 Douglas Street	
10f. ZIP CODE 21643				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7th College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Janitorial	
17. FATHER'S NAME (First, Middle, Last) Roland Strawberry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Washington/ Emma Robinson			
19a. INFORMANT'S NAME (Type/Print) Mable Butler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Gold Rush Lane, Hurlock, Maryland 21643			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veteran Cemetery 2/13/96		20c. LOCATION — City or Town, State Beulah, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of the neck DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Fahed Kouli M.D.				29c. LICENSE NUMBER D48271		29d. DATE SIGNED (Month, Day, Year) 2/15/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FAHED KOULI, M.D. VA MARYLAND HEALTH CARE SYSTEMS, Perry Point, MD 21902							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06581

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELSIE MAE SIMMONS

2. Date of Death

Month Day Year
Jan 13 1996

3. Time of Death

8:30 am

4a. Facility Name (If not institution, give street and number)

9155 Nana Russell Road

4b. City, Town, or Location of Death

Owings

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

213-46-8829

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 11, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Owings

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9155 Nana Russell Road

10f. Zip Code

20736

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
white15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Licensed Practical Nurse

16b. Kind of Business/Industry

Health

17. Father's Name (First, Middle, Last)

James

18. Mother's Name (First, Middle, Maiden Surname)

Ida Mae Altizer

19a. Informant's Name/Relationship (Type, Print)

Daniel W. Simmons / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6019 Ocean Gateway, Queenstown, MD 21658

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

entombment Ft. Lincoln Cemetery Jan 16, 1996 Brentwood, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William R. Griffin

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. HYPERTENSION AND PERIPHERAL VASCULAR DISEASE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John H. Weir

29c. License number

D26358

29d. Date signed (Month, Day, Year)

JAN. 15, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN WEIR, MD - PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

JAN 16 1996

32. Registrar's Signature

John H. Weir

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

10

96 06582

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Antonio Triolo				2. DATE OF DEATH MONTH DAY YEAR February 21, 1996				3. TIME OF DEATH 1:05 P. M.	
4. SOCIAL SECURITY NUMBER 498-62-4160		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) October 14, 1913		8. BIRTHPLACE (State or Foreign Country) Italy	
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Leonardtwn			9c. COUNTY OF DEATH St. Mary's		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION California				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 110 Oak Court				10f. ZIP CODE 20619		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE - American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber			16b. KIND OF BUSINESS/INDUSTRY Defense		
17. FATHER'S NAME (First, Middle, Last) Giacinto Triolo				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Triolo					
19a. INFORMANT'S NAME (Type/Print) Maria Brady				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Oak Court, California, Maryland 20619					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Immaculate Heart of Mary 2/24/96		DATE		20c. LOCATION - City or Town, State Lexington Park, Maryland			
21. SIGNATURE OF FUNERAL SERVICE OFFICER <i>Michael K. Blankenship</i> Michael K. Blankenship				22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary oncos</i> b. <i>Myocardial Infarction/longtime</i> c. <i>Spontaneous failure</i> d. <i>Sepsis</i> Approximate Interval Between Onset and Death 2/21/96 2/96 2/96 2/96									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Some Diabetes</i>									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. Feller MD</i>				29c. LICENSE NUMBER D39158		29d. DATE SIGNED (Month, Day, Year) 2/29/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John M. Feller MD</i>									
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06584

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maude Della Thompson				2. Date of Death Month Day Year February 24, 1996		3. Time of Death 12:00 AM	
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital				4b. City, Town, or Location of Death LaPlata, MD		4c. County of Death Charles County	
Funeral Director	5. Social Security Number 213-74-0331		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) February 11, 1900	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Charles		10c. City, Town or Location Indian Head	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 58 Elder Place		10f. Zip Code 20640		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Her Home			
	17. Father's Name (First, Middle, Last) James Arthur Wiseman				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Wagner			
	19a. Informant's Name/Relationship (Type, Print) Sarah Griffith Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oakgrove Cemetery		Date		20c. Location - City or Town, State Uniontown, Pennsylvania	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md. 20640			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Right cerebral infarct with hemorrhage Due to (or as a consequence of): b. leukocytosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 4 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number D45737		29d. Date signed (Month, Day, Year) 2/24/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirmaladevi Gurusamy, MD 11345 Pembroke Square Suite 104 Waldorf, MD 20603							
31. Date filed (Month, Day, Year) FEB 26 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06585

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MESERET TEKLEMARIAM				2. Date of Death Month FEB Day 21 Year 96		3. Time of Death 11:16 AM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 213-35-1193		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 24 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 3, 1971	9. Birthplace (State or Foreign Country) Ethiopia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 10014 Woodland Drive				10f. Zip Code 20902		10g. Citizen of What Country? Ethiopia		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) Cashier				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry Food Market		
17. Father's Name (First, Middle, Last) Teklemariam				18. Mother's Name (First, Middle, Maiden Summa) Worknesh				
19a. Informant's Name/Relationship (Type, Print) Bisrat Mekuria				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10014 Woodland Drive, Silver Spring, Md. 20902				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Addis Ababa		Date 2/25/96		20c. Location - City or Town, State Ethiopia		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE TRAUMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 24 HRS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FEB 20 96		28b. Time of Injury 10:00 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred 30' FALL FROM WINDOW
		28e. Location (Street and Number or Rural Route Number, City or Town, State) HOME #10						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number DOT099		29d. Date signed (Month, Day, Year) FEB 21 96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS C MAYKE 1025 FERNWOOD RD BETHESDA MD 20817								
31. Date filed (Month, Day, Year) FEB 23 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06586

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles William Teske				2. DATE OF DEATH MONTH DAY YEAR February 20, 1996		3. TIME OF DEATH 5:15 P. M.	
4. SOCIAL SECURITY NUMBER 578-20-5085		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 19, 1924	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 12 G Hillside Road		9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Greenbelt		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12 G Hillside Road				10f. ZIP CODE 20770		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Glass Blower		16b. KIND OF BUSINESS/INDUSTRY United States Government			
17. FATHER'S NAME (First, Middle, Last) Charles William Teske				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Theresa Schaffer			
19a. INFORMANT'S NAME (Type/Print) Debra Ann Teske				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4506 Yates Road Beltsville, Maryland 20705			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 2/21/1996		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic prostate cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Granite, MD				29c. LICENSE NUMBER D17572		29d. DATE SIGNED (Month, Day, Year) 2/21/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David S. Granite, M.D. 115 Center Way Greenbelt, Maryland 20770-1836							
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE John Davidson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06587

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Wallace Trudeau				2. Date of Death Month Day Year February 16, 1996				3. Time of Death 12:30 AM		
	4a. Facility Name (If not institution, give street and number) 2913 Blueridge Avenue				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 502-12-5348		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 13, 1927		9. Birthplace (State or Foreign Country) North Dakota		
	10e. State Maryland				10b. County Montgomery		10c. City, Town or Location Silver Spring				
To Be Completed by Funeral Director	10e. Street and Number 2913 Blueridge Avenue				10f. Zip Code 20902		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-48		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auditor		16b. Kind of Business/Industry Federal Government				
	17. Father's Name (First, Middle, Last) Charisse O. Trudeau				18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Kennedy						
	19a. Informant's Name/Relationship (Type, Print) Mary H. Trudeau				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 Blueridge Avenue Silver Spring, Maryland 20902						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State 2/19/96 Silver Spring, Maryland						
	21. Signature of Funeral Service Licensee Timothy J. Campbell				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. INTERSTITIAL FIBROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 MONTH 46 YEARS						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Steven T. Kariya - MD		29c. License number D36252		29d. Date signed (Month, Day, Year) FEB. 16, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN T. KARIYA, MD, 11501 GEORGIA AVE #515, WHEATON MD 20902				31. Date filed (Month, Day, Year) FEB 20 1996				32. Registrar's Signature John Davidson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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96 06588

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Laura Priscilla Thorne				2. DATE OF DEATH MONTH DAY YEAR February 17, 1996		3. TIME OF DEATH 4:00 A M	
4. SOCIAL SECURITY NUMBER 104-14-3740		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 17, 1921	
9a. FACILITY NAME (If not institution, give street and number) 7520 Rhode Island Ave. #c				9b. CITY, TOWN OR LOCATION OF DEATH College Park		9c. COUNTY OF DEATH Prince George's	
10a. STATE MD.		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION COLLEGE PARK		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7520 RHODE ISLAND AVE. #c				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		15b. KIND OF BUSINESS/INDUSTRY DEPARTMENT STORE			
17. FATHER'S NAME (First, Middle, Last) FRANKLIN F. THORNE				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERNIECE BERRY			
19a. INFORMANT'S NAME (Type/Print) RICHARD LOVE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6419 BALTIMORE AVE., RIVERDALE, MD. 20737			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		DATE 2/20		20c. LOCATION — City or Town, State RIVERDALE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. W. Chambers M00091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → widespread malignancy Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. abnormal spread from ovarian cancer b. ovarian cancer c. d. Approximate Interval Between Onset and Death years years years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER James W. Harding MD		29c. LICENSE NUMBER D05401		29d. DATE SIGNED (Month, Day, Year) February 17, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James W. Harding M.D. 7525 Greenway Center Dr. Greenbelt, MD. 20770							
31. DATE FILED (Month, Day, Year) FEB 20 1996		32. REGISTRAR'S SIGNATURE Juli Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06589

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Finley Thompson, Jr.				2. Date of Death Month February Day 18 , Year 1996		3. Time of Death 4:22 AM	
	4e. Facility Name (If not institution, give street and number) Washington Advenstist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 249-58-3495	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 15, 1940		9. Birthplace (State or Foreign Country) South Carolina
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State	10b. County	10c. City, Town or Location Washington, DC			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 5000 2nd Street, NW, #4			10f. Zip Code 20011		10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Director of Telecommunications			16b. Kind of Business/Industry Howard University		
	17. Father's Name (First, Middle, Last) Finley Thompson, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Irene McGriff			
	19a. Informant's Name/Relationship (Type, Print) Charles F. Thompson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 3rd Street, NW, Washington, DC 20011			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 2-19-96	20c. Location - City or Town, State Beltsville, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS							Approximate Interval Between Onset and Death Few days.
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AIDS							
To Be Completed by Physician/Medical Examiner	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 			29c. License number 042582		29d. Date signed (Month, Day, Year) February 18, 1996		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parmjit Aujla, M. D., 5632 Annapolis Road, #14, Bladensburg, MD 20710							
	31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06590

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAXWELL THOMAS				2. Date of Death Month Day Year Feb 21 1996				3. Time of Death 158P.		
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 215-26-7909		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Sykesville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5514 Mineral Hill Rd.				10f. Zip Code 21784				10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) horse trainer				16b. Kind of Business/Industry horse farm		
	17. Father's Name (First, Middle, Last) (unknown)				18. Mother's Name (First, Middle, Maiden Surname) (unknown)						
	19a. Informant's Name/Relationship (Type, Print) Dr. Raymond T. Murphy				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5476 Mineral Hill Rd. Sykesville, MD 21784						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery		Data 2/23/96		20c. Location - City or Town, State Westminster, MD		
	21. Signature of Funeral Service Licensee Catherine O. Hartzler				22. Name and Address of Facility D.D. Hartzler & Sons Union Bridge, MD						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. POSSIBLE SEPTICAEMIC SHOCK Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate interval Between Onset and Death 12 HRS						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Hafeez Syed				29c. License number D25052		29d. Date signed (Month, Day, Year) 2/21/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAFAEZ SYED 30 CROSS Roads Dr, Owings Mills				31. Date filed (Month, Day, Year) FEB 23 1996				32. Registrar's Signature John D. Hartzler			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

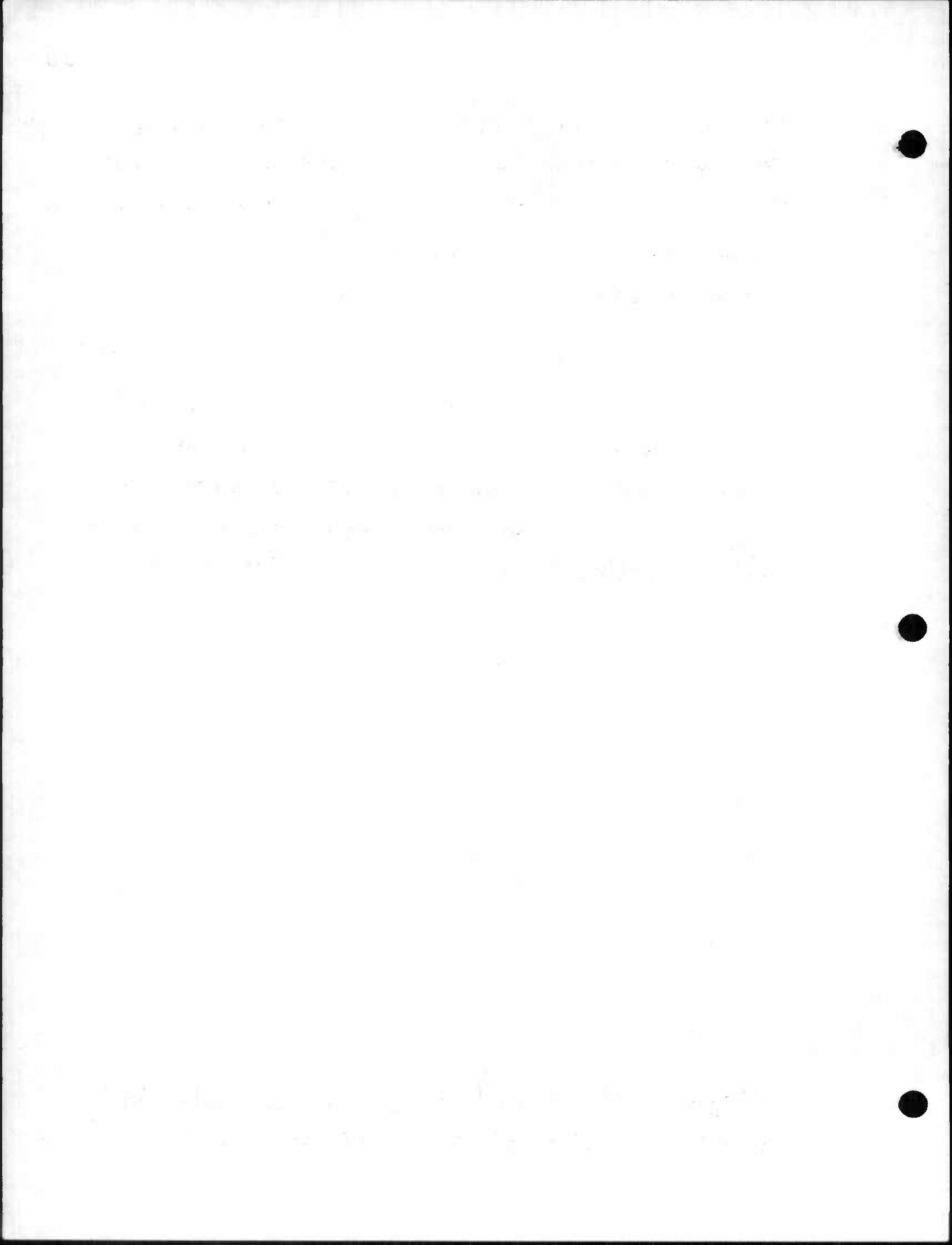
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHELLE DIANE TORRES				2. Date of Death Month Day Year FEB. 15 1996		3. Time of Death 11:04 PM 12:45 PM			
	4a. Facility Name (If not institution, give street and number) FALLSTON GENERAL HOSPITAL				4b. City, Town, or Location of Death FALLSTON		4c. County of Death HARFORD			
Funeral Director	5. Social Security Number 255-59-7606		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 13 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 5, 1982		9. Birthplace (State or Foreign Country) Texas	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Joppa			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 348 Trimble Road				10f. Zip Code 21085		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student			16b. Kind of Business/Industry Middle School				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Thomas Daniel Torres				18. Mother's Name (First, Middle, Maiden Surname) Beatrice Jane Weidman					
	19a. Informant's Name/Relationship (Type, Print) Margaret Torres - Adopted Mom				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Trimble Rd., Joppa, Maryland 21085					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Eaton Cemetery		Date 2/22/96		20c. Location - City or Town, State Mount Eaton, Ohio			
	21. Signature of Funeral Service Licensee Shelly K. McComas				22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hanging Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? XX Yes 2 <input type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? XX Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Found 2-15-96		28b. Time of Injury (Month, Day, Year) Found 2-13 p M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject hanged self		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dennis J. Chute MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 17, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature John Andrew Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06592

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Louise TAYLOR</i>				2. Date of Death Month <i>FEB</i> Day <i>9</i> Year <i>1996</i>		3. Time of Death <i>4:51 A</i>	
	4a. Facility Name (If not institution, give street and number) <i>WASHINGTON ADVENTIST HOSPITAL</i>				4b. City, Town, or Location of Death <i>Takoma Park</i>		4c. County of Death <i>Montgomery</i>	
Funeral Director	5. Social Security Number <i>578-60-4515</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>52</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 1, 1943</i>	
	9. Birthplace (State or Foreign Country) <i>South Carolina</i>		10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Hyattsville</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>7100 23rd Avenue</i>		10f. Zip Code <i>20783</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Negro</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Retired Acct. Tech.</i>		16b. Kind of Business/Industry <i>Government</i>			
	17. Father's Name (First, Middle, Last) <i>George Tompkins</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Mamie Borum</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Joseph L. Taylor - Husband</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7100 23rd Avenue, Hyattsville, Maryland 20783</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ft. Lincoln Cemetery</i>		20c. Location - City or Town, State <i>2/14/96 Brentwood, Maryland</i>			
	21. Signature of Funeral Service Licensee <i>John T. Stewart III</i>		22. Name and Address of Facility <i>STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Acute Asthma</i> Due to (or as a consequence of): <i>Chronic Asthma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Obstructive Sleep Apnea</i> <i>Hypertensive Cardiovascular Disease</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Jeffrey Munger M.D.</i>		29c. License number <i>D12582</i>		29d. Date signed (Month, Day, Year) <i>February 9, 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>7600 Carroll Avenue Takoma Park, Maryland 20912</i>		31. Date filed (Month, Day, Year) <i>FEB 20 1996</i>		32. Registrar's Signature <i>John Anderson</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06593

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Johnetta Dolores Gardner Taylor				2. DATE OF DEATH MONTH 2 DAY 14 YEAR 96		3. TIME OF DEATH 1:00 PM	
4. SOCIAL SECURITY NUMBER 290-24-1212		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-2-1917	
9a. FACILITY NAME (If not institution, give street and number) Atlantice General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Berlin		9c. COUNTY OF DEATH Worcester	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Lanham		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9108 Wallace Road				10f. ZIP CODE 20706		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 4+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Government			
17. FATHER'S NAME (First, Middle, Last) John Gardner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy McCleod			
19a. INFORMANT'S NAME (Type/Print) Selena Price/Niece				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Old Stage Road, Bishopville 21813 Maryland			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 2/19		20c. LOCATION — City or Town, State Brentwood, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kimbely C Busch-Tonic				22. NAME AND ADDRESS OF FACILITY J. B. Jenkins Funeral Home 7474 Landover Road, Landover 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's disease Senile dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Patricia Mahoney M.D.				29c. LICENSE NUMBER D4 6490		29d. DATE SIGNED (Month, Day, Year) 2/14/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patricia Mahoney MD Atlantice General Hospital							
31. DATE FILED (Month, Day, Year) FEB 21 1996		32. REGISTRAR'S SIGNATURE John A. Woodcock					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

96 06594

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) ALVA LEE TAYLOR				2. DATE OF DEATH MONTH FEBRUARY DAY 13 YEAR 1996				3. TIME OF DEATH 6:05 PM					
4. SOCIAL SECURITY NUMBER 579-07-2126		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) April 30, 1914		8. BIRTHPLACE (State or Foreign Country) Talladega, AL					
9a. FACILITY NAME (If not institution, give street and number) Fort Washington Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Ft. Washington, MD			9c. COUNTY OF DEATH Prince Georges						
RESIDENCE OF DECEDENT													
10a. STATE DC		10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 1720 Webster Street N.E.				10f. ZIP CODE 20017		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Postal Supervisor			16b. KIND OF BUSINESS/INDUSTRY U.S. Post Office							
17. FATHER'S NAME (First, Middle, Last) John Taylor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Wilson									
19a. INFORMANT'S NAME (Type/Print) Lorraine McCottry Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Webster St., N.E., Wash., DC 20017									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery 2-23-96			DATE		20c. LOCATION — City or Town, State Suitland, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.P. Marshall</i>				22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4217 9th St., N.W. Wash., DC 20011									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <table border="0"> <tr> <td rowspan="3" style="font-size: 3em; vertical-align: middle;">{</td> <td>b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>c. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>d.</td> </tr> </table>								{	b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF):	c. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):	d.	Approximate Interval Between Onset and Death	
{	b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF):												
	c. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):												
	d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			29c. LICENSE NUMBER D24064		29d. DATE SIGNED (Month, Day, Year) FEB 14, 1996						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHANTHA MURTHY 6196 Oxon Hill Rd. OXON HILL, MD 20745													
31. DATE FILED (Month, Day, Year) FEB 20 1996		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

THE
UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06595

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rayfield Thomas				2. Date of Death Month 2 Day 17 Year 96		3. Time of Death 11:30 A	
	4a. Facility Name (If not institution, give street and number) Hwy A Hs Village Manor				4b. City, Town, or Location of Death Hwy A Hs Village		4c. County of Death md, DC	
Funeral Director	5. Social Security Number 579-10-7541		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 5/4/09	
	9. Birthplace (State or Foreign Country) Cherryville, N.C.		10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 X Yes 2 No		10e. Street and Number 4843 KANSAS AVE. NW		10f. Zip Code 20011		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 X Yes 2 No		14. Race - American Indian, Black, White, etc. Specify:	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer		16b. Kind of Business/Industry National Security Agency		17. Father's Name (First, Middle, Last) Solomon Thomas	
	18. Mother's Name (First, Middle, Maiden Surname) JANIE HARRIS		19a. Informant's Name/Relationship (Type, Print) EVANGELINE J. THOMAS wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4843 KANSAS AVE. N.W. D.C. 20011		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln		20c. Date 2/16/96		20d. Location - City or Town, State Md. Bladensburg		21. Signature of Funeral Service Licensee Doyle Dillard Jr	
	22. Name and Address of Facility MODERN FUNERAL HOME 3821-14TH ST. N.W. WASH. D.C. 20011		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. multiple myeloma - end stage Due to (or as a consequence of): b. Renal Failure Due to (or as a consequence of): c. ANEMIA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 No 2 X Yes 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 No 2 X Yes	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 No 2 X Yes		25. Was case referred to medical examiner? 1 No 2 X Yes		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	
	28a. Date of Injury (Month, Day, Year) 2/11/96		28b. Time of Injury 11:30 P M		28c. Injury at Work? 1 No 2 X Yes		28d. Describe how injury occurred Natural Death	
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D46834	
	29d. Date signed (Month, Day, Year) 2/13/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY RUTH LOPEZ MD 7243 Henderson Parkway greenbelt md. 20770		31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature [Signature]	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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24th

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Amended # 18, 2/22/96, Nels, Allegany Co.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN NELSON THRASHER Jr.				2. DATE OF DEATH MONTH FEBRUARY DAY 18 YEAR 1996				3. TIME OF DEATH 8:48PM M	
4. SOCIAL SECURITY NUMBER 216078497		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 13, 1917		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Lonaconing				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 20603 Brodie Road				10f. ZIP CODE 21539				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Spinning Dept.				16b. KIND OF BUSINESS/INDUSTRY Textile	
17. FATHER'S NAME (First, Middle, Last) John Nelson Thrasher Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pansy McFarlane Fazenbaker					
19a. INFORMANT'S NAME (Type/Print) Ruth E. Marsh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18311 Laurel Run Rd. S.W. Moscow Mills, Barton, Md. 21521					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Mem. Park Feb. 21, 1996 Frostburg, Maryland				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. McKee</i>				22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPERTENSIVE CARDIOVASCULAR HEART DISEASE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 20 YEARS								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. IDIOPATHIC HYPERTROPHIC SUBAORTIC STENOSIS								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> DPTY MED				29c. LICENSE NUMBER EX D09157				29d. DATE SIGNED (Month, Day, Year) FEB 18, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL SNOW, M.D. 124 W 3RD ST CUMBERLAND MD 21502									
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE <i>John Nelson Thrasher</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06597

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DALLAS SCOTT TOWNSEND				2. DATE OF DEATH MONTH DAY YEAR Feb. 21, 1996		3. TIME OF DEATH 1:25 A M	
4. SOCIAL SECURITY NUMBER 216-04-9988		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 24 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 22, 1972	
8. FACILITY NAME (If not institution, give street and number) 13408 McMullen Highway SW; POTOMAC PARK				9. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		10. COUNTY OF DEATH ALLEGANY	
11. STATE MD		12. COUNTY Allegany		13. CITY, TOWN OR LOCATION Cresaptown		14. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15. STREET AND NUMBER 12719 Meadow Avenue				16. ZIP CODE 21502		17. CITIZEN OF WHAT COUNTRY? USA	
18. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: white	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Live-in Counselor		24. KIND OF BUSINESS/INDUSTRY United Cerebral Palsy			
25. FATHER'S NAME (First, Middle, Last) Billie Dwayne Townsend				26. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia L. (Hendershot)			
27. INFORMANT'S NAME (Type/Print) Billie Townsend				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12719 Meadow Avenue; Cresaptown, MD 21502			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 02/23		31. LOCATION — City or Town, State Cumberland, MD			
32. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				33. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Self inflicted intra-oral gun shot wound							
SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): Major Depression							
b. DUE TO (OR AS A CONSEQUENCE OF): Atypical Conduct Disorder							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
36. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
37. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		38. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Parking Lot					
39. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		40. DATE OF INJURY (Month, Day, Year) Feb 20, 1996		41. TIME OF INJURY 11:55 P M		42. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
43. DESCRIBE HOW INJURY OCCURRED Self inflicted gunshot wound		44. LOCATION (Street and Number or Rural Route Number, City or Town, State) 13408 McMullen Hwy; Cumberland, MD 21502					
45. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
46. SIGNATURE AND TITLE OF CERTIFIER Dr. Paul Snow				47. LICENSE NUMBER D09157		48. DATE SIGNED (Month, Day, Year) Feb 21, 1996	
49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502							
50. DATE FILED (Month, Day, Year) FEB 22 1996				51. REGISTRAR'S SIGNATURE John H. Hendershot			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22 pages

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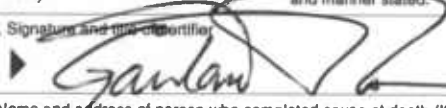
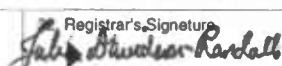
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06598

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles RICHARD Todd				2. Date of Death Month Feb Day 18 Year 1996		3. Time of Death 1305 Pm	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 216-44-8566		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) MAY 27, 1946	
	9. Birthplace (State or Foreign Country) MARYLAND							
To Be Completed by Funeral Director	10a. State MD		10b. County QUEEN ANNE'S		10c. City, Town or Location CENTREVILLE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 118 KIDWELL AVENUE				10f. Zip Code 21617		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES MANAGER		16b. Kind of Business/Industry LUMBER COMPANY			
	17. Father's Name (First, Middle, Last) FRANKLIN B. TODD				18. Mother's Name (First, Middle, Maiden Surname) MADALINE BUTLER			
	19a. Intomment's Name/Relationship (Type, Print) HELEN M. TODD/ WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 KIDWELL AVENUE, CENTREVILLE, MD 21617			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESTERFIELD CEMETERY 2-22		20c. Location - City or Town, State CENTREVILLE, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage Due to (or as a consequence of): Intraentricular Hemorrhage Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number AU4176435AT2818		29d. Date signed (Month, Day, Year) Feb 18 96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) G THAKUR M.D. 22. S. Greene St. Baltimore, Md #21201								
31. Date filed (Month, Day, Year) FEB 20 1996		Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Louise Umberger				2. DATE OF DEATH MONTH DAY YEAR February 18, 1996		3. TIME OF DEATH 9:20p M	
4. SOCIAL SECURITY NUMBER 216-22-0874		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 25, 1927	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 19 School Dr. Apt. #104 Bldg. 19		9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 19 School Drive Apt. #104 Bldg. 19	
10f. ZIP CODE 20878				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Room Inspector		16b. KIND OF BUSINESS/INDUSTRY Hotel Industry	
17. FATHER'S NAME (First, Middle, Last) Leo Swann				18. MOTHER'S NAME (First, Middle, Maiden Surname) Erma Agnus Reed			
19a. INFORMANT'S NAME (Type/Print) Diane Custer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Misty Dale Way, Gaithersburg, MD 20877			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 2/21/96		20c. LOCATION — City or Town, State Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Culligan</i>				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic colon cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 35 mos.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George A. Sotos MD</i>				29c. LICENSE NUMBER 43083		29d. DATE SIGNED (Month, Day, Year) Feb. 19, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George A. Sotos 9707 Medical Center Drive #300, Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06600

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JANET TAYLOR VENCELOV				2. Date of Death Month Day Year February 24 1996				3. Time of Death 1:20 AM			
	4a. Facility Name (If not institution, give street and number) Meridian Nursing Center				4b. City, Town, or Location of Death La Plata				4c. County of Death CHARLES			
Funeral Director	5. Social Security Number 579-09-2032		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 28 1919		9. Birthplace (State or Foreign Country) Scotland			
	Usual Residence of Decedent				10a. State Maryland				10b. County Charles		10c. City, Town or Location Waldorf	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3422 Williamsburg Drive				10f. Zip Code 20601		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) John Gordon				18. Mother's Name (First, Middle, Maiden Summa) Elizabeth Taylor							
	19a. Informant's Name/Relationship (Type, Print) George M. Vencelov (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3422 Williamsburg Dr. Waldorf, MD 20601							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 2-25-96				20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee John H. Eberwein M00173				22. Name and Address of Facility J.H. Eberwein Mortuary 4433 White Plains Lane White Plains, MD 20695							
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARCINOMA OF LUNG								Approximate Interval Between Onset and Death FEW YRS			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D-44436				29d. Date signed (Month, Day, Year) FEBRUARY 24 196			
	29b. Signature and title of certifier Atteny											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR J PATEL 603 POSTOFFICE ROAD WALDORF MD 20602											
	31. Date filed (Month, Day, Year) FEB 27 1996				32. Registrar's Signature Julia Davidson-Randall							
	State Registrar											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06601

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

REVEKKA VLADAVSKAYA

2. Date of Death

Month Day Year
FEBRUARY 14, 1996

3. Time of Death

12:18 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

212-96-9498

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
NOV. 9, 1923

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14508 HOMECREST ROAD #215

10f. Zip Code

20905

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

PRINTING

17. Father's Name (First, Middle, Last)

GREGORY TEPLITZKY

18. Mother's Name (First, Middle, Maiden Surname)

ESFIR TEPLITZKY

19a. Informant's Name/Relationship (Type, Print)

ROSTY VLADAVSKY (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15713 ALLENWOOD DRIVE - SILVER SPRING, MARYLAND 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

2/16

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

lung abscess.

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes mellitus, Sarcoidosis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38457

29d. Date signed (Month, Day, Year)

February 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. G. G. 1811 Prince Philip Dr Olney MD 20852

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06602

Amended #10f, MRT, 2/23/96, Montg. Cty Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELVA Y. VAN WINKLE				2. Date of Death Month Day Year FEB. 19, 1996		3. Time of Death 0911 A.M.		
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 579-58-5577		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 10, 1906		
	9. Birthplace (State or Foreign Country) COLORADO		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location GAITHERSBURG		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19310 CLUBHOUSE ROAD		10f. Zip Code 20878 20879		10g. Citizen of What Country? U.S.A.	
11. Marital Status XX <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIBRARIAN		16b. Kind of Business/Industry DC GOVERNMENT		17. Father's Name (First, Middle, Last) CHARLES THORN VAN WINKLE		18. Mother's Name (First, Middle, Maiden Surname) ELVA HUBARD YOUNG	
19a. Informant's Name/Relationship (Type, Print) JOHN Mc BRYDE, NEPHEW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19437 TRANSHIRE RD, GAITHERSBURG, MD. 20879		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY		20c. Location - City or Town, State ALEXANDRIA, VA.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVE. N.W., WASHINGTON, D.C. 20016		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death MINS. YEARS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death XX <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 37024		29d. Date signed (Month, Day, Year) FEB. 19, 1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID G. SROUR, M.D. 9901 MEDICAL CENTER DR. ROCKVILLE, MD.		31. Date filed (Month, Day, Year) FEB 23 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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96 06603

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZA S. VOGT				2. DATE OF DEATH MONTH 2 DAY 22 YEAR 96		3. TIME OF DEATH 8:10A M	
4. SOCIAL SECURITY NUMBER 213-05-1252		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 4, 1915	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) CARROLL LUTHERAN VILLAGE		9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER	
9c. COUNTY OF DEATH CARROLL				10a. STATE MARYLAND		10b. COUNTY CARROLL	
10c. CITY, TOWN OR LOCATION WESTMINSTER				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3033 SYKESVILLE RD.	
10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? USA.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK		16b. KIND OF BUSINESS/INDUSTRY RETAIL SALES	
17. FATHER'S NAME (First, Middle, Last) CHESTER C. SHIPLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA W. WILLIAMS			
19a. INFORMANT'S NAME (Type/Print) JUDY FURBAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2163 GREEN MILL RD., FINKSBURG, MD. 21048			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY 2/24/96 PIKESVILLE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>P. Lary</i>				22. NAME AND ADDRESS OF FACILITY FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Adenocarcinoma of uncertain primary Approximate Interval Between Onset and Death 1 YR Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>James L. Forsberg</i>			
29c. LICENSE NUMBER D33561				29d. DATE SIGNED (Month, Day, Year) 2-22-96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James L. Forsberg, MD 912 Washington Rd, Westminster, MD							
31. DATE FILED (Month, Day, Year) FEB 23 1996				32. REGISTRAR'S SIGNATURE <i>Julia Anderson Randall</i>			

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

96 06604

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS EARL VAUGHT				2. DATE OF DEATH MONTH Feb DAY 16 YEAR 1996		3. TIME OF DEATH 4:42 pm	
4. SOCIAL SECURITY NUMBER 223-22-8935		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 1, 1923	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Bel Air				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2721 Creswell Road	
10f. ZIP CODE 21015				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) Pastor				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ministry		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Arthur (u/k) Vaught				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine (u/k) Handy			
19a. INFORMANT'S NAME (Type/Print) Irene Vaught				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2721 Creswell Road, Bel Air, Maryland 21015			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens 2/20/96 Aldino, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen A. Hughes</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION							
DUE TO (OR AS A CONSEQUENCE OF):							
b. CORONARY ARTERY DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
d. cerebral vascular disease							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael N. Drossner MD</i>				29c. LICENSE NUMBER D32288		29d. DATE SIGNED (Month, Day, Year) February 16, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL N. DROSSNER M.D. 104 PLUMTREE RD. SUITE 110 BEL AIR, MD. 21015							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended 2-22-96 - tlp
Item #6 - 81 yo
Item #10a. - 200 Civic Ave.

96-06605

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH					
MARY Elizabeth WINTERBOTTOM				Feb. 18 1996				3:10 P M					
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)					
220-44-4701		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		82 81 YRS.		Feb 21, 1914		Maryland					
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
SALISBURY NURSING & REHAB CENTER				SALISBURY, MD.				WICOMICO					
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Maryland				Wicomico		Salisbury		<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?							
200 Civic Avenue				21801		US							
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.							
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White							
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 11				College (1-4 or 5+) 2				did not work					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)									
William Grason Winterbottom				Nannie Davis									
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Hubert H. Wright IV				P.O. Box 778, Cambridge MD 21613									
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)				20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Christ Episcopal Churchyard 2/21/ Cambridge, Md.									
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY									
				Thomas Funeral Home, P.A. 700 Locust St. Cambridge, Maryland 21613									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease												yes	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												yes	
DUE TO (OR AS A CONSEQUENCE OF): Diabetes												yes	
DUE TO (OR AS A CONSEQUENCE OF): Perforated Stomach												yes	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED?												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)									
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
2 <input type="checkbox"/> Accident													
3 <input type="checkbox"/> Suicide													
4 <input type="checkbox"/> Homicide													
8 <input type="checkbox"/> Could not be determined													
29a. CERTIFIER (Check only one)				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)					
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				D-29349				2/18/96					
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
WILLIAM ROBINS, M.D., 1104 Healthway Dr., Salisbury, Md. 21804													
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE									
FEB 22 1996													



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Denton Josephine Williams				2. DATE OF DEATH MONTH February DAY 19 YEAR 1996		3. TIME OF DEATH 11:30 P M		
4. SOCIAL SECURITY NUMBER 236-32-0580		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 31, 1912		
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 3 Manor Road		9b. CITY, TOWN OR LOCATION OF DEATH Elkton		
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil		
10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3 Manor Road		
10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KING OF BUSINESS/INDUSTRY n/a				
17. FATHER'S NAME (First, Middle, Last) Roby B. Spencer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rubena C. Hamm				
19a. INFORMANT'S NAME (Type/Print) Robert H. Williams, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 Table Rock Road - Pickens, SC 29671				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park 2/23/1996		20c. LOCATION — City or Town, State Elkton, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 30yrs							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. Farkas, MD</i>				29c. LICENSE NUMBER D15314		29d. DATE SIGNED (Month, Day, Year) February 20, 1996		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. Farkas, MD, Northern Chesapeake Hospice, 239 S. Bridge St., Elkton, MD 21921								
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20250000

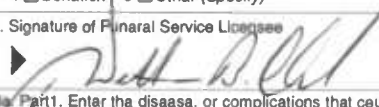

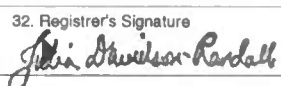
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06607

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA L. WINKLER				2. Date of Death Month Day Year FEB. 16, 1996				3. Time of Death 6:50 PM			
	4a. Facility Name (If not institution, give street and number) Manor Care Bethesda				4b. City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 220-26-4447		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1913		9. Birthplace (State or Foreign Country) Washington, D.C.			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 8809 Jones Mill Road				10f. Zip Code 20815		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Florist			16b. Kind of Business/Industry Wholesale				
	17. Father's Name (First, Middle, Last) Bernhard Winkler				18. Mother's Name (First, Middle, Maiden Surname) Hermine Thalman							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Fred B. Winkler (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8728 Susanna Lane, Chevy Chase, MD 20815							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 2-18-96 Beltsville, MD					
	21. Signature of Funeral Service Licensee  M00827				22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Normal Pressure Hydrocephalus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28e. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier  Merlyn Vemury, M.D.				29c. License number D35791		29d. Date signed (Month, Day, Year) February 17, 1996					
State Registrar	30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Merlyn Vemury, M.D. 9801 Georgia Ave #227, Silver Spring, MD 20902											
	31. Date filed (Month, Day, Year) FEB 20 1996				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

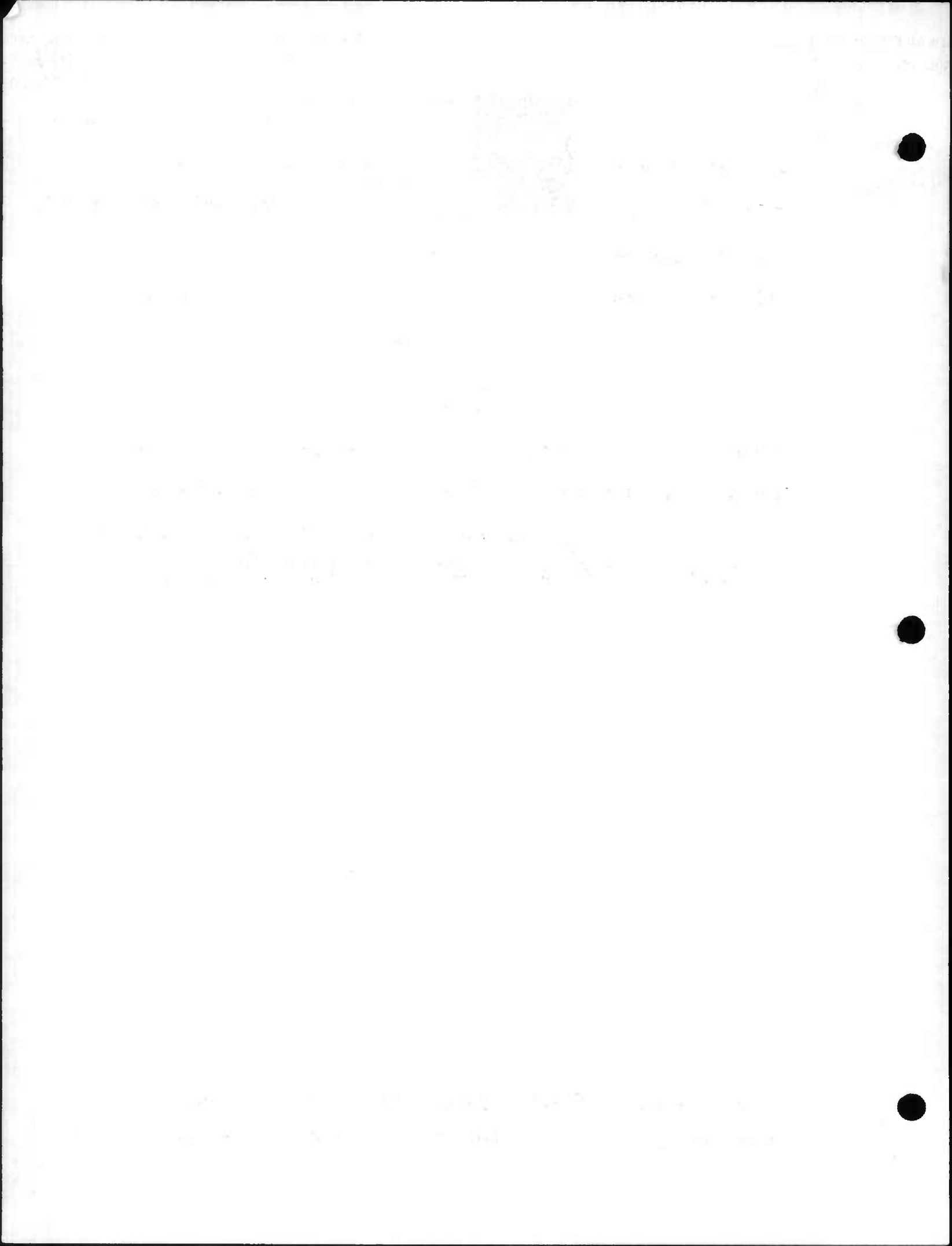
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06608

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY C. WU				2. Date of Death Month Day Year February 12, 1996				3. Time of Death 10:10 AM					
	4a. Facility Name (If not institution, give street and number) 8017 Whittier Boulevard				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 202-34-3663		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) May 21, 1935		9. Birthplace (State or Foreign Country) China	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number 8017 Whittier Boulevard				10f. Zip Code 20817				10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Chinese					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor				16b. Kind of Business/Industry Education					
	17. Father's Name (First, Middle, Last) Tsong-Xian Wu				18. Mother's Name (First, Middle, Maiden Surname) S. Y. Lin									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Teresa C. Wu Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8017 Whittier Blvd., Bethesda, MD 20817									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park 2-17-96				20c. Location - City or Town, State Rockville, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. PANCREATIC CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d.												Approximate Interval Between Onset and Death 1/2 HOUR 3 MONTHS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 				29c. License number MD. D37587				29d. Date signed (Month, Day, Year) 15 Feb 96						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID P. JACQUES, M.D. DEPT. SURGERY, WALTER REED AHC, WASH. D.C.														
State Registrar		31. Date filed (Month, Day, Year) FEB 20 1996		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

96 06609

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Irvin Wheeler				2. DATE OF DEATH MONTH DAY YEAR February 21, 1996				3. TIME OF DEATH 6:00 a.m.	
4. SOCIAL SECURITY NUMBER 219-14-9339		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) March 27, 1924				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 1119 Main St.				9b. CITY, TOWN OR LOCATION OF DEATH Hampstead, MD 21074				9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Hampstead				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1119 Main St.				10f. ZIP CODE 21074		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner				16b. KIND OF BUSINESS/INDUSTRY Wheeler Chevrolet	
17. FATHER'S NAME (First, Middle, Last) William Leslie Wheeler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Olive Fringer					
19a. INFORMANT'S NAME (Type/Print) Janice E. Wheeler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 Main St., Hampstead, MD 21074					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hampstead Cemetery		DATE 2/24		20c. LOCATION — City or Town, State Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Eline</i>				22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S. Main St., Hampstead, MD 21074					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Deogracias Faustino, MD</i>				29c. LICENSE NUMBER D12901		29d. DATE SIGNED (Month, Day, Year) 2/21/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Deogracias Faustino, 4111 Lower Beckleysville Rd., Hampstead, MD 21074									
31. DATE FILED (Month, Day, Year) FEB 23 1996				32. REGISTRAR'S SIGNATURE <i>Juba Davidson-Rodell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06610

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eugene William Welsh				2. Date of Death Month Day Year February 13 1996		3. Time of Death 11:30 A.M.	
	4a. Facility Name (If not institution, give street and number) 3737 Harmony Church Road				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 216-12-6050		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 18, 1923	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Harford		10c. City, Town or Location Havre de Grace	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 3737 Harmony Church Road		10f. Zip Code 21078	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1952	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 7	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting				16b. Kind of Business/Industry U.S. Government			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Eugene W. Welsh, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna McGovern			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Nancy Jane Welsh (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3737 Harmony Church Rd., Havre de Grace, MD 21078			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc.			
	20c. Date 2/14/96				20d. Location - City or Town, State West Chester, PA			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Gary R. DiGiovanni				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. metastatic colon cancer to liver Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 15 months			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Feb 15 1996			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Matilda H. So, MD			
	29c. License number D-26250				29d. Date signed (Month, Day, Year) 2/14/96			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATILDA H. So, 1447 York Rd, Lutherville, MD 21093				31. Data filed (Month, Day, Year) FEB 15 1996			
	Registrar's Signature John Michael Randall							

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06611

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shedrick L. Willis Sr.						2. Date of Death Month Day Year February 18, 1996		3. Time of Death 0723	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital						4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 514-40-6973		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) July 26, 1940		9. Birthplace (State or Foreign Country) Florida	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Aberdeen				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 502 Plaza Court Apt. 1-A				10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman			15b. Kind of Business/Industry Pipe Manufacturing		
	17. Father's Name (First, Middle, Last) Edward Willis						18. Mother's Name (First, Middle, Maiden Surname) Blanche Rogers			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Blanche Willis						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1427 Perrywood Drive, Aberdeen, Maryland 21001			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Company		20c. Location - City or Town, State 2/22/96 West Chester, PA			
	21. Signature of Funeral Service Licensee Gary R. di Miazumi						22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. myocardial infarction Due to (or as a consequence of): b. cardiomyopathy Due to (or as a consequence of): c. hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier M. Benner, MD						29c. License number D37693		29d. Date signed (Month, Day, Year) 2/18/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Benner Harford mem. Hosp.										
State Registrar	31. Date filed (Month, Day, Year) FEB 22 1996				32. Registrar's Signature David Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06612

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <p align="center">Maria L. Walter</p>				2. Date of Death Month Day Year Feb. 13 1996		3. Time of Death <p align="center">5 AM</p>	
	4a. Facility Name (If not institution, give street and number) 16000 B English Oaks Ave.				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577 22 1003		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1918	
	9. Birthplace (State or Foreign Country) Washington D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 16000 B English Oaks Ave.		10f. Zip Code 20716		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Retail			
	17. Father's Name (First, Middle, Last) William F. Reagan				18. Mother's Name (First, Middle, Maiden Surname) Minnie Matthews			
	19a. Informant's Name/Relationship (Type, Print) Earle Walter Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16000 B. English Oaks Ave. Bowie Maryland 20716			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Suitland Maryland			
	21. Signature of Funeral Service Licensee <i>Robert E. Evans, Pres.</i>		22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Road Bowie Maryland 20715					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <i>cardiac arrhythmias</i> Due to (or as a consequence of):</p> <p>b. <i>myocardial infarction</i> Due to (or as a consequence of):</p> <p>c. <i>coronary artery disease</i> Due to (or as a consequence of):</p> <p>d.</p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Diabetes Mellitus II</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Thomas K. MD</i>				29c. License number D 22 111		29d. Date signed (Month, Day, Year) 2/13/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS K. MD 1100 Good Luck Rd #302 Lanham MD 20706								
31. Date filed (Month, Day, Year) FEB 21 1996				32. Registrar's Signature <i>John Shuler-Ravall</i>				

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Marie WHEELER				2. DATE OF DEATH MONTH DAY YEAR February 11, 1996		3. TIME OF DEATH 8:10 P.M.	
4. SOCIAL SECURITY NUMBER 578-05-8283		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 20, 1908	
9a. FACILITY NAME (If not institution, give street and number) DOCTOR'S COMMUNITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LANHAM		9c. COUNTY OF DEATH PRINCE GEORGE'S	
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION	
						WASHINGTON, D.C.	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3911 20TH STREET, N.E.				10f. ZIP CODE 20018		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) CLYDE LOMAX				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE TOLIVER			
19a. INFORMANT'S NAME (Type/Print) TERESA WHEELER, DAUGHTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 20TH STREET, N.E., WASHINGTON, D.C. 20018			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY 2/17/96		20c. LOCATION — City or Town, State BRENTWOOD, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY FORT LINCOLN FUNERAL HOME, INC. 3401 BLADENSBURG RD., BRENTWOOD, MD 20722			
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>a. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): SINUS</p> <p>d. PERIPHERAL VASCULAR DISEASE</p> <p>DICUBITUS ULCER. RENAL FAILURE</p>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D20757		29d. DATE SIGNED (Month, Day, Year) 2-12-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Aroor Rao 8100 Good Luck Road Suite 302 Lanham, MD 20706							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22-10-1980 20:00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06614

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LUCILLE E. WALDEN				2. Date of Death Month FEBRUARY Day 9 Year 1996		3. Time of Death 830 P	
	4e. Facility Name (If not institution, give street and number) 8612 WILLOW AVENUE				4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 212-66-6136		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) June 9, 1914	
	9. Birthplace (State or Foreign Country) Gibsonville, NC		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Upper Marlboro, Maryland	
Usual Residence of Decedent								
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 8612 Willow Avenue				10f. Zip Code 20772		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical Supervisor			16b. Kind of Business/Industry Government		
17. Father's Name (First, Middle, Last) John Powell				18. Mother's Name (First, Middle, Maiden Surname) Leatha Faust				
19a. Informant's Name/Relationship (Type, Print) Naomi Brown/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8612 Willow Avenue Upper Marlboro, Maryland 20772				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham Cemetery		Data 2/15/96		20c. Location - City or Town, State Cheltenham, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) Ischemic heart disease - cardiovascular disease</p> <p>Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. _____ Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 15%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			26f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D21230		29d. Date signed (Month, Day, Year) February 10, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) August P. Rodriguez, MD, 5009 Rayburn Ct. Cp. - S.W. MD 20748								
31. Date filed (Month, Day, Year) FEB 20 1996			32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

96 06615

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carroll C Weikel				2. DATE OF DEATH MONTH DAY YEAR Feb 18 1996		3. TIME OF DEATH 6:49AM M	
4. SOCIAL SECURITY NUMBER 227-56-7896		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 52 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov 24 1943		8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE W.VA.		10b. COUNTY MINERAL		10c. CITY, TOWN OR LOCATION RIDGELEY		10d. INSIDE CITY LIMITS? t <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RFD#2 BOX#47				10f. ZIP CODE 25440		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CSX RAILROAD/SHEET METAL		16b. KIND OF BUSINESS/INDUSTRY CSX RAILROAD TRANSPORTATION			
17. FATHER'S NAME (First, Middle, Last) CARROLL B. WEIKEL				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHLEEN CURTIS			
19a. INFORMANT'S NAME (Type/Print) CATHERINE RHEA WEIKEL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#2 BOX#47 RIDGELEY, W.VA. 25440			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) MOUNTAIN VIEW CEMETERY FEB 21 1996		20c. LOCATION — City or Town, State CLIFTON FORGE, VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction							
DUE TO (OR AS A CONSEQUENCE OF): Coronary artery heart disease							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: t <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> Dpty Med Ex				29c. LICENSE NUMBER D 09157		29d. DATE SIGNED (Month, Day, Year) Feb 18, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w 3rd st Cumberland Md 21502							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

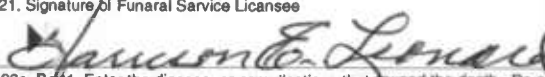

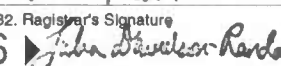
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06616

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BESSIE MAY WILSON				2. Date of Death Month 02 Day 20 Year 96		3. Time of Death 3:30 p.m.		
	4a. Facility Name (If not institution, give street and number) Caroline Nursing Home				4b. City, Town, or Location of Death Denton		4c. County of Death Caroline		
Funeral Director	5. Social Security Number 212-18-2323		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 18, 1898	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Talbot		10c. City, Town or Location St. Michaels			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 519 Tenant Circle				10f. Zip Code 21663		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Charles A. Buchman				18. Mother's Name (First, Middle, Maiden Surname) Martha Myers					
19a. Informant's Name/Relationship (Type, Print) Robert A. Wilson Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1018 St. Michaels, Maryland 21663					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery			20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediata Cause (Final disease or condition resulting in death)</p> <p>a. Myocardial Infarction Due to (or as a consequence of):</p> <p>b. ASCVD with CHF Due to (or as a consequence of):</p> <p>c. TBP Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>5 hours</p> <p>10+ years</p> <p>30+ years</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sacral Decubitus Ulcer, Depression, Corneal Dystrophy						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D33294		29d. Date signed (Month, Day, Year) 2/20/96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rob Lappin MD 920 Market St. Denton, Md. 21629									
31. Date filed (Month, Day, Year) FEB 22 1996				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06617

Item: 23 part II, per ME0 6-734 4/2/96 reb

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL WERTHEIMER			2. Date of Death Month Day Year FEBRUARY 15, 1996			3. Time of Death 12:09P			
	4a. Facility Name (If not institution, give street and number) EASTON MEMORIAL HOSPITAL			4b. City, Town, or Location of Death EASTON			4c. County of Death TALBOT			
Funeral Director	5. Social Security Number 214-05-8352		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 8, 1916		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Talbot			10c. City, Town or Location St. Michaels			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 24580 Deep Water Pt. Drive					10f. Zip Code 21663		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist			16b. Kind of Business/Industry Drug store		
17. Father's Name (First, Middle, Last) Samuel Wertheimer						18. Mother's Name (First, Middle, Maiden Surname) Stella Lichtenstein				
19a. Informant's Name/Relationship (Type, Print) Elizabeth S. Wertheimer - Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24580 Deep Water Pt. Drive #4, St. Michaels, MD. 21663				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory			Date Feb 17, 1996		20c. Location - City or Town, State Dover, Delaware		
21. Signature of Funeral Service Licensee <i>Harrison E. Leonard</i>						22. Name and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot Street, St. Michaels, MD, 21663				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple injuries</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Antihypertensive Cardiovascular Disease</i> HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) 2/15/96		28b. Time of Injury 1:55 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Subject drove of vehicle struck w/ent</i>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Theodore H. King</i>			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 16, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE H. KING</i> 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) FEB 20 1996			32. Registrar's Signature <i>John Andrew Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

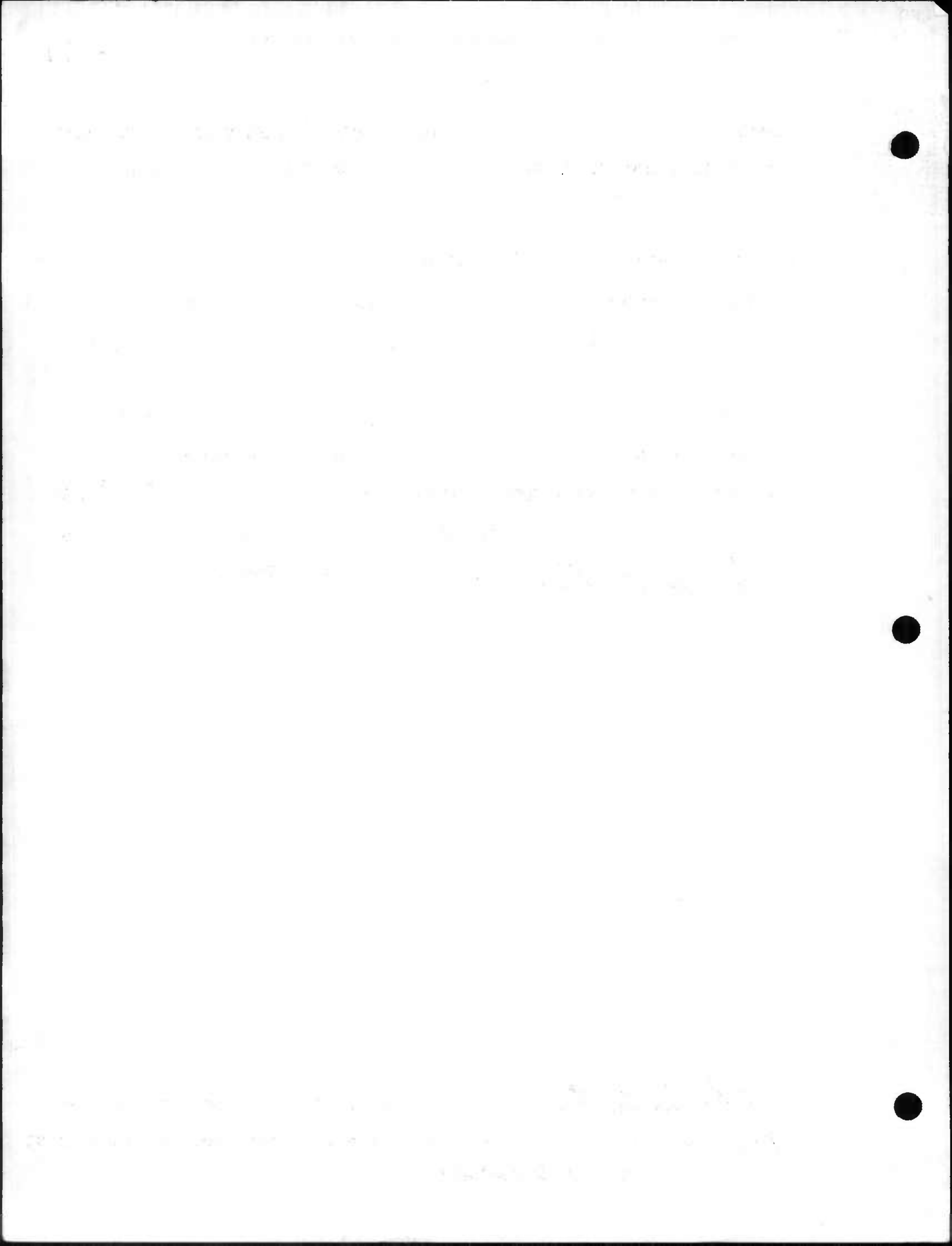
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



96 06618

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leura Younker				2. DATE OF DEATH MONTH DAY YEAR February 16 1996		3. TIME OF DEATH 4:40 A M	
4. SOCIAL SECURITY NUMBER 283-20-2057		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 27, 1908	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 415 Russell Avenue, #601				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Kindergarten Teacher		15b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Daniel W. Younker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriett Wenger			
19a. INFORMANT'S NAME (Type/Print) Myra Younker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. LOCATION — City or Town, State 2-18 Beltsville, Maryland		20d. DATE 2-18	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent hyponatremia						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James R. Moore Jr. MD				29c. LICENSE NUMBER 07231		29d. DATE SIGNED (Month, Day, Year) February 16, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Moore Jr. 207 Brookers Ave Gaithersburg Md 20877							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06619

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Loyd Ralph Young

2. Date of Death
Month Day Year

Feb. 20, 1996

3. Time of Death
7:50 AM

4a. Facility Name (If not Institution, give street and number)

2664 Conowingo Rd.

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

226-16-1271

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

March 22, 1917

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

2664 Conowingo Rd.

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

Collage (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Fabrication

17. Father's Name (First, Middle, Last)

Luther Melvin Young

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Beatrice Halsey

19a. Informant's Name/Relationship (Type, Print)

Virginia O. Young

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2664 Conowingo Rd., Bel Air, Md. 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Memorial Gardens 2-23-96 Bel Air, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Howard K. McComas III

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
50 W. Broadway St., Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Myocardial Infarction
Due to (or as a consequence of):

6 hours

b. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

10 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury
(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenn L Snyder MD

29c. License number

D33642

29d. Date signed (Month, Day, Year)

February 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenn L Snyder MD 754 Hickory Avenue Bel Air MD 21014

State
Registrar

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

John Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06620

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD YOUNG				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20 1996		3. TIME OF DEATH 5:03 P M	
4. SOCIAL SECURITY NUMBER 577-07-2436		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 27, 1910	
8. BIRTHPLACE (State or Foreign Country) Wash., DC				9. COUNTY OF DEATH PRINCE GEORGE			
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CLINTON			
10a. STATE --				10b. COUNTY --			
10c. CITY, TOWN OR LOCATION Washington, D.C.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2303 Savannah St., S.E.				10f. ZIP CODE 20020		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Delivery			
17. FATHER'S NAME (First, Middle, Last) George Young				18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Timber			
19a. INFORMANT'S NAME (Type/Print) George Young, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Carmody Hills Dr. Capitol Heights, Md.			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Pk 2-24-96		20c. LOCATION — City or Town, State Landover, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Theron Johnson-Salley	
22. NAME AND ADDRESS OF FACILITY Capitol Mortuary		23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): SERVIS DUE TO (OR AS A CONSEQUENCE OF): Metastatic Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate interval Between Onset and Death 6 hrs 10 hrs 2 years		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Daryl Mathews				29c. LICENSE NUMBER D45435		29d. DATE SIGNED (Month, Day, Year) 2/21/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SOUTHERN MARYLAND HOSPITAL Clinton MD.							
31. DATE FILED (Month, Day, Year) FEB 22 1996				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1921-22 100 100 100 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06621

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORRAINE Louise AUSTIN				2. Date of Death Month MARCH Day 5 Year 1996		3. Time of Death 17:00pm										
	4a. Facility Name (If not institution, give street and number) 1631 Cliftview Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A										
Funeral Director	5. Social Security Number 202-20-6256	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 13, 1929		9. Birthplace (State or Foreign Country) CARLISE, PA									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State MD	10b. County n/a	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
	10e. Street and Number 1631 CLIFTVIEW AE.			10f. Zip Code 21213		10g. Citizen of What Country? UNITED STATES											
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year of Discharge:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK										
	15. Decedent's Education (Specify only highest grade completed) 8 th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry FACTORY												
	17. Father's Name (First, Middle, Last) GEORGE COOPER				18. Mother's Name (First, Middle, Maiden Surname) AGNES COOPER												
	19a. Informant's Name/Relationship (Type, Print) LUCRETIA AUSTIN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 TENTIMLL LANE apt.A, BALTIMORE, MD 21208												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		20c. Location - City or Town, State CATONSVILLE, MD		20d. Date 3-9										
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Probable STROKE Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 HOUR</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Possible Cardiac Dysrhythmia Due to (or as a consequence of):</td> <td>HOURS</td> </tr> <tr> <td>c. Hypertension Due to (or as a consequence of):</td> <td>> 20 YEARS</td> </tr> <tr> <td>d. Atrial Fibrillation Due to (or as a consequence of):</td> <td>> 2 YEARS</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Probable STROKE Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 HOUR	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Possible Cardiac Dysrhythmia Due to (or as a consequence of):	HOURS	c. Hypertension Due to (or as a consequence of):	> 20 YEARS	d. Atrial Fibrillation Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Probable STROKE Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 HOUR															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Possible Cardiac Dysrhythmia Due to (or as a consequence of):	HOURS															
	c. Hypertension Due to (or as a consequence of):	> 20 YEARS															
	d. Atrial Fibrillation Due to (or as a consequence of):	> 2 YEARS															
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Idiopathic Pulmonary Fibrosis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number L8820		29d. Date signed (Month, Day, Year) 3/7/96											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER BROVERMAN Johns Hopkins Hospital 600 N. Wolfe Street, Baltimore 21205																	
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registered Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06622

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT ALLEN

2. Date of Death

MARCH 06, 1996

3. Time of Death

0420 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

215-18-7038

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 12, 1907

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

#23 HOBART COURT

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Water Dept.

17. Father's Name (First, Middle, Last)

Milton Allen

18. Mother's Name (First, Middle, Maiden Surname)

Sophie (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Vernon Holland - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#23 Hobart court, Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park 3/11 Arbutus, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, INC.
4600 LIBERTY HEIGHTS AVENUE, BALTO. 21207

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC PROSTATIC CA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. J. Imperia, Jr. MD

29c. License number

D44J05

29d. Date signed (Month, Day, Year)

MARCH 06, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. J. IMPERIA, JR. NORTHWEST HOSP. CENTER

31. Date filed (Month, Day, Year)

MAR 07 1996

32. Registrar's Signature

J. J. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

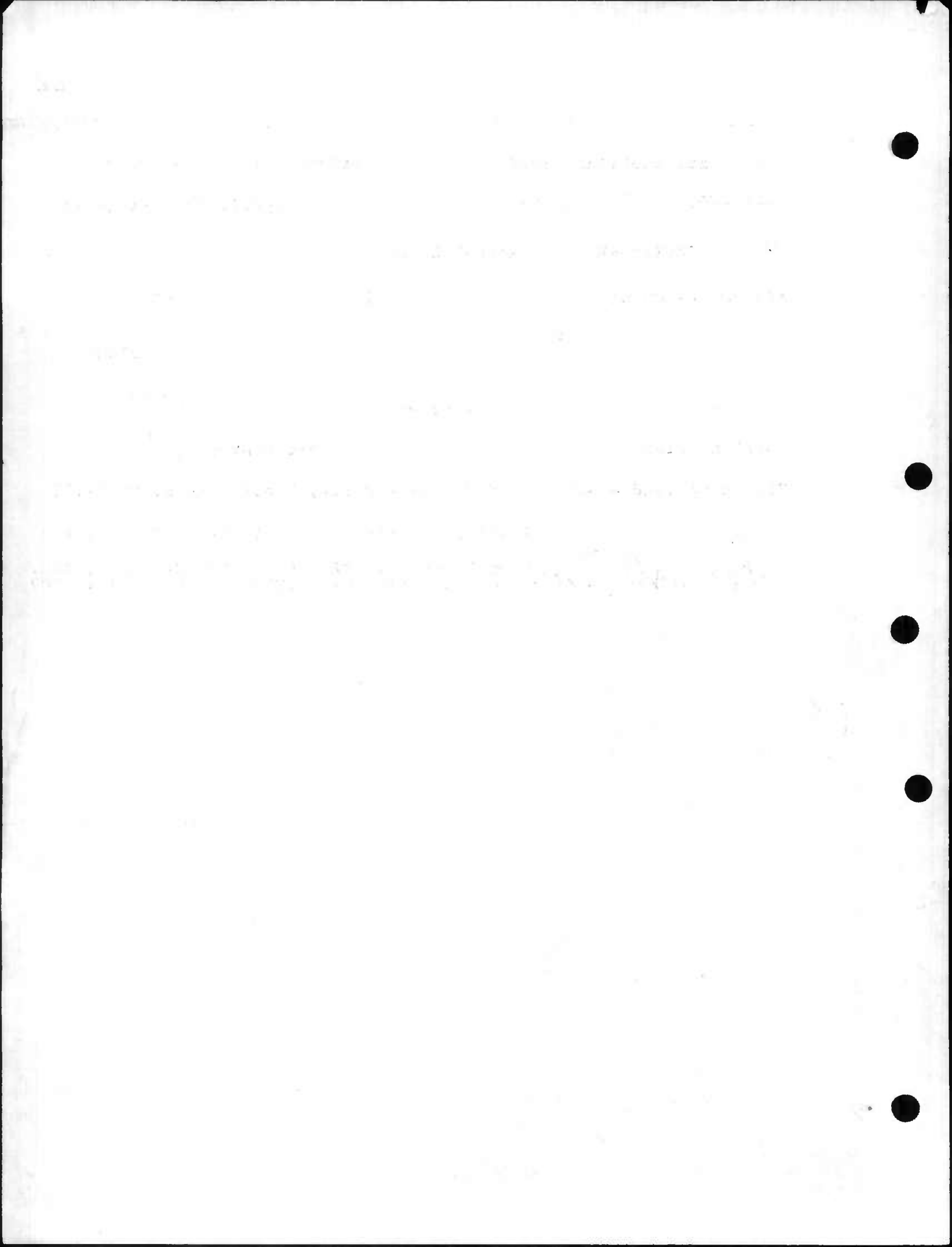
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06623

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel R. Anderson				2. DATE OF DEATH MONTH March DAY 5 YEAR 1996		3. TIME OF DEATH 2:50 P.M.	
4. SOCIAL SECURITY NUMBER 212 07 8607		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 30, 1899	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace	
9c. COUNTY OF DEATH Harford				10a. STATE MARYLAND			
10b. COUNTY HARFORD				10c. CITY, TOWN OR LOCATION BELAIR			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 22 COLONIAL ROAD			
10f. ZIP CODE 21014				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YRS. College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AT HOME		16b. KIND OF BUSINESS/INDUSTRY HOUSEWIFE	
17. FATHER'S NAME (First, Middle, Last) EDWARD L. JACOBS				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH BELL WALKER			
19a. INFORMANT'S NAME (Type/Print) MURRAY F. ANDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3119 HABERSHAM HILLS ROAD CUMMING GA. 30131			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY		20c. LOCATION — City or Town, State BALTIMORE MARYLAND		20d. DATE 3-6	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL - BELAIR, MD 3 NEWPORT DRIVE FOREST HILL MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ACUTE MI</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CABINETS</u> - <u>CHF</u> <u>DEMENTIA</u> - <u>NEUMONIA</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD				29c. LICENSE NUMBER D42800		29d. DATE SIGNED (Month, Day, Year) 3/5/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) T. Biondo MD, CMP, 3195 UNION AVE, HARBOR, MD, 21078							
31. DATE FILED (Month, Day, Year) MAR 07 1996		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06624

Reg. No.

12

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

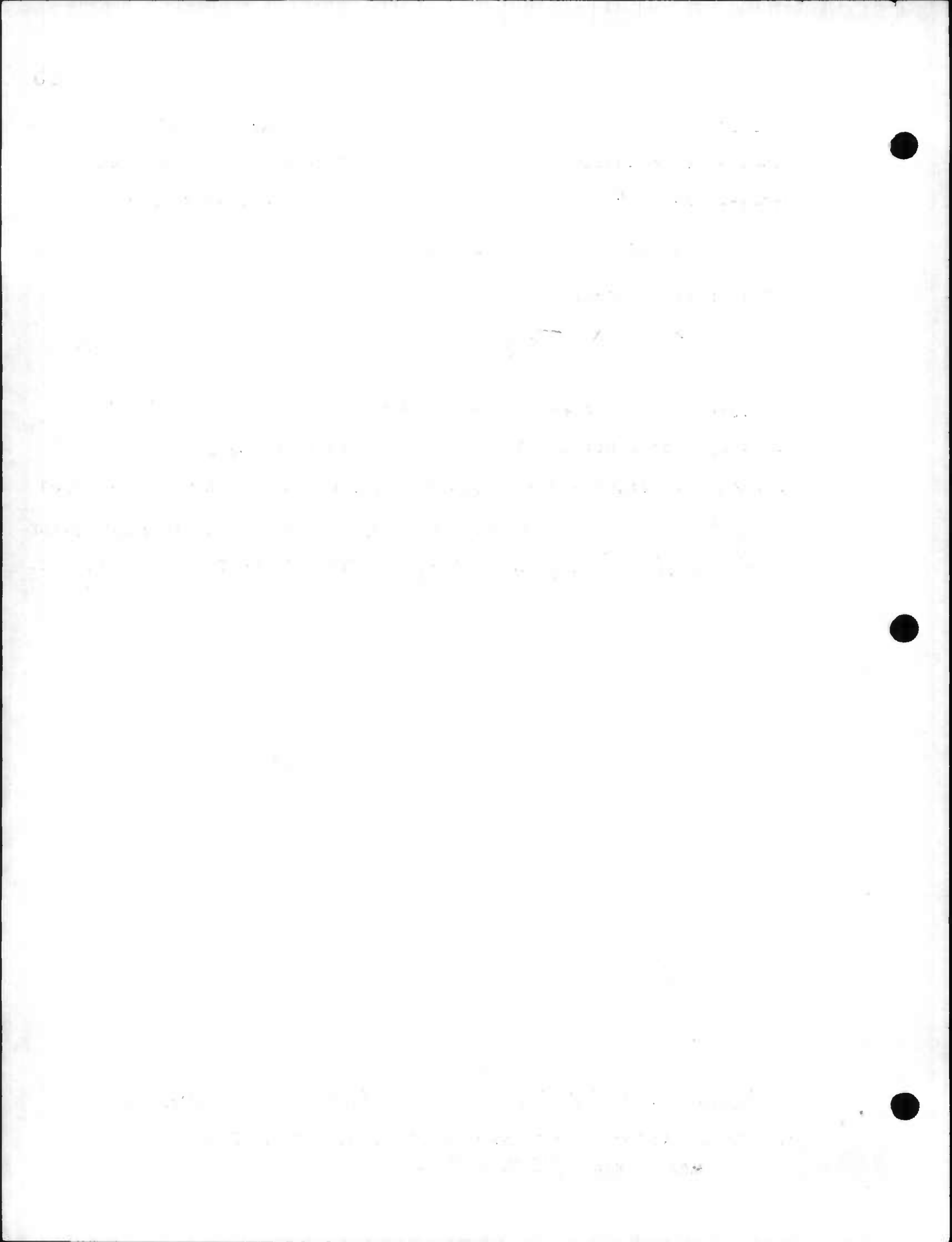
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) CHARLES BRIGHT				2. Date of Death Month March Day 4 Year 1996		3. Time of Death 7:00 P.M.	
4a. Facility Name (If not Institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
5. Social Security Number 047-26-0542		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 8, 1933	
9. Birthplace (State or Foreign Country) Florida							
10a. State MD		10b. County Howard		10c. City, Town or Location Columbia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9203 Creek Bed Court				10f. Zip Code 21045		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1956 - 1977		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4 +				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur		16b. Kind of Business/Industry Courier	
17. Father's Name (First, Middle, Last) Rev. Sylvester Bright, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lucille Boyer			
19a. Informant's Name/Relationship (Type, Print) Kenneth J. Bright - son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6318 Johnny Cake Rd. Baltimore, MD 21207			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 3/7		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>				22. Name and Address of Facility LERROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE BALTO. 21207			
23a. Partly Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTRIC CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Kendall R Faulkner</i>				29c. License number D25643		29d. Date signed (Month, Day, Year) 3/5/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature <i>John Davidson-Randall</i>			



96 06626

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Stanley Bracey				2. DATE OF DEATH MONTH 3 DAY 4 YEAR 1996		3. TIME OF DEATH 6:45 PM	
4. SOCIAL SECURITY NUMBER 218-98-8104		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 34 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUN. 12, 1961	
8a. FACILITY NAME (If not institution, give street and number) 2525 W. BELVEDERE AVENUE				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		8c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 807 N. MILTON AVENUE				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES XX		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED		16b. KIND OF BUSINESS/INDUSTRY MENTALLY CHALLENGED			
17. FATHER'S NAME (First, Middle, Last) STANLEY J. BRACEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) CAROLE BRACEY			
19a. INFORMANT'S NAME (Type/Print) CAROLE BRACEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 N. MILTON AVENUE, BALTIMORE, MD 21205			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 3-8		20c. LOCATION — City or Town, State BALTIMORE CO, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS							
Approximate interval between Onset and Death unknown							
Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure Senile disorder							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D27569		29d. DATE SIGNED (Month, Day, Year) 3/1/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen Hettlerman 1777 Keister town Rd #365							
31. DATE FILED (Month, Day, Year) MAR 0 7 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 6. PER F.H. FILM G-733 3/7/96 t.t

96 06627

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nicholas J. Brader Jr.				2. DATE OF DEATH MONTH DAY YEAR March 2, 1996		3. TIME OF DEATH 5:00 P M	
4. SOCIAL SECURITY NUMBER 216-24-8418		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC 19, 1929	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not institution, give street and number) 8205 LASALLE RD.		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION TOWSON		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8205 LASALLE RD.				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1948 - 1952		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN		16b. KIND OF BUSINESS/INDUSTRY LIFE INSURANCE			
17. FATHER'S NAME (First, Middle, Last) NICHOLAS J. BRADER SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA D. HOFFMAN			
19a. INFORMANT'S NAME (Type/Print) LEONE BRADER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8205 LASALLE RD. TOWSON 21204			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CREMATORY		20c. LOCATION — City or Town, State BALTIMORE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. 21234					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension, Essential DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <15 MIN. 12 years ⊕ 16 years ⊕							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cancer of Urinary Bladder Diabetes mellitus							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 015144		29d. DATE SIGNED (Month, Day, Year) March 5, 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Luke Terry, MD 9655 Chevrolet Dr. Ellicott City, Md 21042							
31. DATE FILED (Month, Day, Year) MAR 07 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

The first part of the report
 deals with the general situation
 of the country and the
 progress of the work
 during the year.
 The second part
 contains the results of the
 investigations and the
 conclusions drawn from them.
 The third part
 contains the recommendations
 for the future work.
 The fourth part
 contains the summary of the
 work done during the year.
 The fifth part
 contains the list of the
 references.

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 The fifth part
 contains the list of the
 references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06628

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret A. Binder

2. Date of Death

March 6, 1996

3. Time of Death

5:38 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

5. Social Security Number

212-12-0651

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 27, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore, City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6511 Glenoak Ave.

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Brough

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Bowling

19a. Informant's Name/Relationship (Type, Print)

Mrs. Barbara Foard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2407 Bond Road, Parkton, Maryland 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park

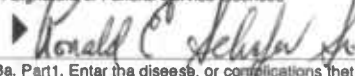
Date

3/9/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road - Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gram Negative Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. End Stage Renal Disease

Due to (or as a consequence of):

d. Laryngeal Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

89233

29d. Date signed (Month, Day, Year)

March 6, 1996

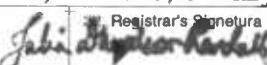
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arwinnah Baustista, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

MAR 0 7 1996

Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

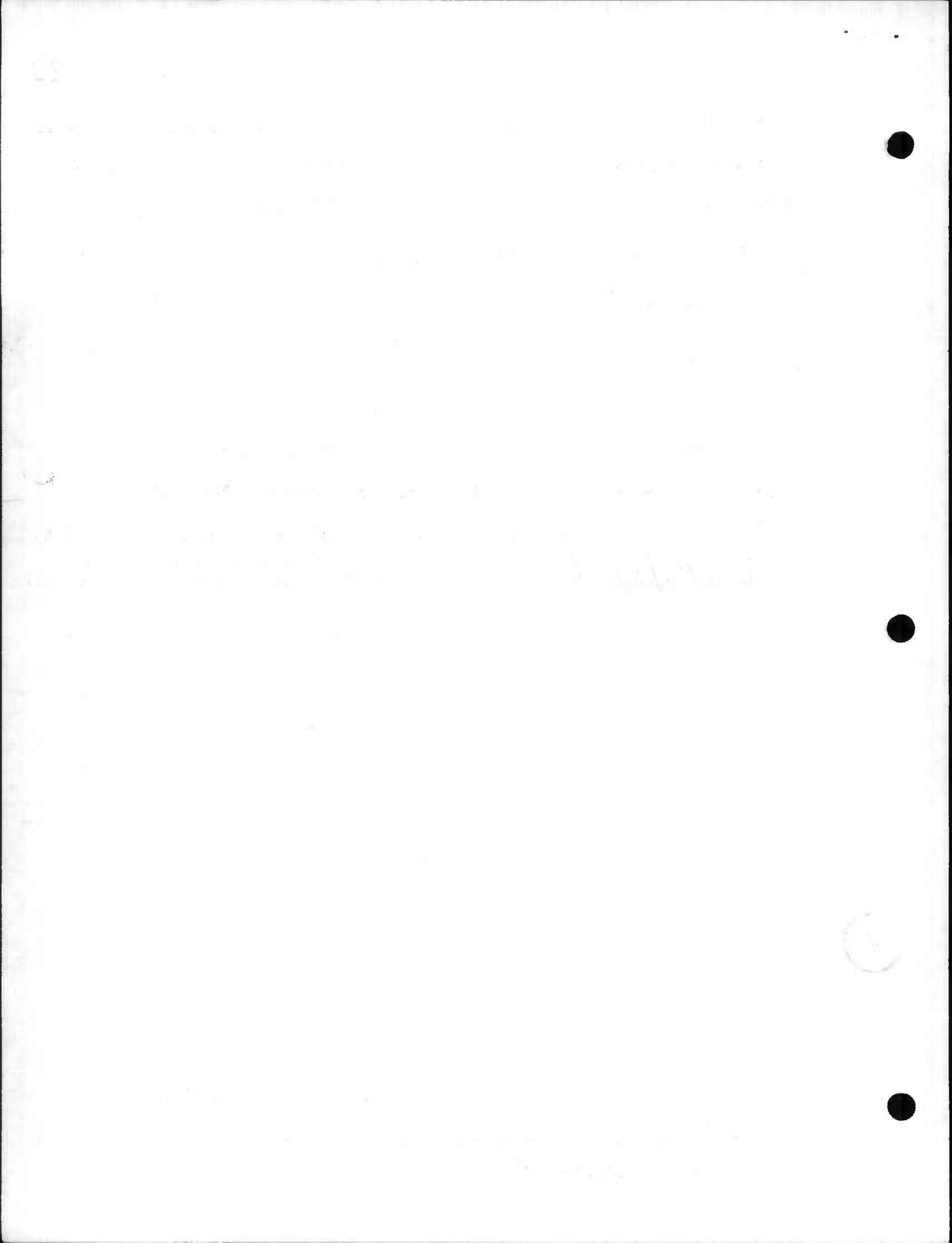
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: All death certificates have been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06629

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA COLLEEN BAKER				2. Date of Death Month MARCH Day 6 Year 1996		3. Time of Death 7:48 A.M.	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213-48-5725		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 15, 1950	9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore		10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1100 Kenilworth Dr.			10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) Service Help			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bennington's		16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) William S. Baker				18. Mother's Name (First, Middle, Maiden Summa) Dorothy L. Fitzgerald			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Dorothy L. Baker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Kenilworth Dr. Towson, Md. 21204			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park		Data 3/9/96		20c. Location - City or Town, State Baltimore, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. respiratory failure Due to (or as a consequence of): b. Obesity - Hypoventilation Syndrome Due to (or as a consequence of): c. Prader-Willi Syndrome Due to (or as a consequence of): d.							
	Approximate Interval Between Onset and Death Approx. 4 weeks Approx. 1 yr Birth							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D25205		29d. Date signed (Month, Day, Year) 3/6/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GPMC 6701 N. Charles St. Balto. Md. 21208								
31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

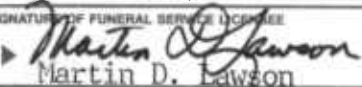
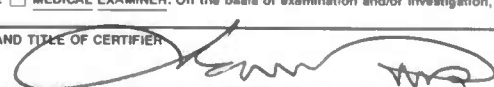
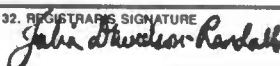
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNARD JAMES BARLAGE				2. DATE OF DEATH MONTH Mar DAY 5 YEAR 1996		3. TIME OF DEATH 11:00 pm	
4. SOCIAL SECURITY NUMBER 216-14-7648		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 30, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore County	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8007 York Road, Apt A2	
10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 yrs			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Saleman				16b. KIND OF BUSINESS/INDUSTRY Insurance Company			
17. FATHER'S NAME (First, Middle, Last) Bernard Barlage				18. MOTHER'S NAME (First, Middle, Maiden Surname) Honora Madden			
19a. INFORMANT'S NAME (Type/Print) Ms. Margaret (Peggy) M. Bruns				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 York Road, Towson, Maryland 21204			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory			
20c. LOCATION — City or Town, State Baltimore, Maryland				20d. DATE 3/9			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Martin D. Lawson				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE CEREBROVASCULAR ACCIDENT CHRONIC RENAL FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 3/9			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  BOON P. LIM, MD				29c. LICENSE NUMBER D 37254			
29d. DATE SIGNED (Month, Day, Year) 3-6-96				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BOON P. LIM, MD ST. JOSEPH MEDICAL CENTER TOWSON, MARYLAND 21204			
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE  John A. Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06631

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID BUTLER				2. Date of Death Month: MARCH 5, 1996 Day: Year:				3. Time of Death 11:50 A		
	4a. Facility Name (If not Institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A		
Funeral Director	5. Social Security Number 237-16-6670		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 13, 1918		9. Birthplace (State or Foreign Country) NORTH CAROLINA		
	10a. State MARYLAND				10b. County N/A		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1222 N. BROADWAY				10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No MAY 28, 1942 If Yes, Give Year or Dates: DEC. 6, 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH College (1-4or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry CONTAINER CORP. OF AMERICA				
	17. Father's Name (First, Middle, Last) ELIZHA BUTLER				18. Mother's Name (First, Middle, Maiden Surname) NELLIE BANNISTER						
	19a. Informant's Name/Relationship (Type, Print) JOANN BUTLER -WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 N. BROADWAY BALTO, MD. 21213						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATIONAL MEM. PK.		20c. Location - City or Town, State LAUREL, MARYLAND				
	21. Signature of Funeral Service Licensee Calvin B. Scruggs				22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gram Negative Sepsis Due to (or as a consequence of): b. Pseudomonas pneumonia Due to (or as a consequence of): c. Dermatomyositis Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 3 days 10 days 2 years				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Diabetes Mellitus Type II				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Alain Bertoni				29c. License number L9363		29d. Date signed (Month, Day, Year) March 5, 1996	
30. Name and address of person who completed cause of death (Item 22a) (Type, Print) Alain Bertoni 600 N Wolfe Street Baltimore MD 21287				31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature John H. ...			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

6+1

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes tables, figures, and text describing the findings of the research.

4. The fourth part of the report is a discussion of the results and their implications. It includes a comparison of the findings with previous research and a discussion of the limitations of the study.

5. The fifth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study, and the references list the sources of information used in the research.

6. The sixth part of the report is an appendix containing additional information related to the study. This may include raw data, detailed calculations, or other supporting materials.

7. The seventh part of the report is a final summary of the study. It provides a brief overview of the entire report and highlights the key findings.

8. The eighth part of the report is a list of acknowledgments. This section is used to thank individuals or organizations that provided assistance or support during the research process.

9. The ninth part of the report is a list of abbreviations and a glossary. This section helps to clarify the meaning of terms and symbols used throughout the report.

10. The tenth part of the report is a final review of the study. It provides a final assessment of the quality of the research and the reliability of the findings.

11. The eleventh part of the report is a list of references. This section lists the sources of information used in the research, providing a way for readers to locate the original sources.

12. The twelfth part of the report is an appendix containing additional information related to the study. This may include raw data, detailed calculations, or other supporting materials.

13. The thirteenth part of the report is a final summary of the study. It provides a brief overview of the entire report and highlights the key findings.

14. The fourteenth part of the report is a list of acknowledgments. This section is used to thank individuals or organizations that provided assistance or support during the research process.

15. The fifteenth part of the report is a list of abbreviations and a glossary. This section helps to clarify the meaning of terms and symbols used throughout the report.

16. The sixteenth part of the report is a final review of the study. It provides a final assessment of the quality of the research and the reliability of the findings.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06632

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) WALTER CLARENCE CONKLIN, JR.				2. Date of Death Month Day Year March 5, 1996		3. Time of Death 1:50 A.M.	
4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
5. Social Security Number 213-26-5250		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) April 2, 1930	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Cockeysville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 918 Coteswoid Circle		10f. Zip Code 21030		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer		16b. Kind of Business/Industry Engineering		17. Father's Name (First, Middle, Last) Walter Clarence Conklin, Sr.	
18. Mother's Name (First, Middle, Maiden Surname) Anna Eva Gunner		19a. Informant's Name/Relationship (Type, Print) Mrs. Joan L. Conklin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Coteswoid Circle, Cockeysville, MD 21030		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. March		20c. Location - City or Town, State Timonium, Maryland		21. Signature of Funeral Service Licensee Bryan W. Elary		22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BLADDER CANCER, metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 9 months.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Kendall Faulkner	
29c. License number D25643		29d. Date signed (Month, Day, Year) 3/5/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204		31. Date filed (Month, Day, Year) JAN 26 1996	
32. Registrar's Signature J. Davidson-Rendell							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06633

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>William OLIVER Chase JR.</u>				2. Date of Death Month <u>MARCH</u> Day <u>1</u> Year <u>1996</u>		3. Time of Death <u>04:31 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Maryland General Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>553-34-2094</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>75</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Mar. 17. 1920</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>							
Usual Residence of Decedent								
10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>1736 McCulloh Street</u>				10f. Zip Code <u>21217</u>		10g. Citizen of What Country? <u>United States</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 th</u> College (1-4 or 5+) <u>-</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Shoe Shiner</u>			16b. Kind of Business/Industry <u>Self-Employed</u>	
17. Father's Name (First, Middle, Last) <u>William Oliver Chase, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Hazelle Hicks</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Beverly Todd</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6729 Wilmont Drive, Baltimore, MD 21207</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest VA Cem.</u>		Date <u>3-7-96</u>		20c. Location - City or Town, State <u>Owings Mills, MD</u>		
21. Signature of Funeral Service Licensee <u>Shelvia M. Davis</u>				22. Name and Address of Facility <u>March Funeral Home</u> <u>1101 E. North Avenue, Baltimore, MD 21202</u>				
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e. <u>Recent Myocardial Infarct</u> Due to (or as a consequence of): b. <u>Severe Coronary arteriosclerosis</u> Due to (or as a consequence of): c. <u>Small sigmoid colon adenocarcinoma</u> Due to (or as a consequence of): d.								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Duodenal diverticulosis</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>David Ho</u>		29c. License number <u>89205</u>		29d. Date signed (Month, Day, Year) <u>3-1-96</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>David Ho, M.D. c/o Maryland General Hospital</u>								
31. Date filed (Month, Day, Year) <u>MAR 07 1996</u>		32. Registrar's Signature <u>[Signature]</u>						

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Yeh Hwa Chung</u> AGNES YEH-HWA CHUNG				2. DATE OF DEATH MONTH <u>3</u> DAY <u>4</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>12:35A</u> M	
4. SOCIAL SECURITY NUMBER <u>212-88-7957</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>78</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) May 26, 1918	
8. FACILITY NAME (If not institution, give street and number) <u>mt Hi medical</u>				9. CITY, TOWN OR LOCATION OF DEATH <u>7700 Park Rd</u>		10. COUNTY OF DEATH <u>Towson MD</u>	
11. STATE <u>Maryland</u>		12. COUNTY <u>Baltimore</u>		13. CITY, TOWN OR LOCATION <u>Glen Arm</u>		14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
15. STREET AND NUMBER <u>13210 Manor Road</u>				16. ZIP CODE <u>21057</u>		17. CITIZEN OF WHAT COUNTRY? <u>Taiwan</u>	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <u>Asian</u>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>n/a</u>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Teacher</u>		24. KIND OF BUSINESS/INDUSTRY <u>Education</u>			
25. FATHER'S NAME (First, Middle, Last) <u>Hsu Ping</u>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hsu Lin Ying</u>			
27. INFORMANT'S NAME (Type/Print) <u>Wun-Vaei Chung</u>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13210 Manor Road, Glen Arm, Maryland 21057</u>			
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>St. John's Cemetery</u>		31. DATE <u>09</u>		32. LOCATION — City or Town, State <u>March Ellicott City, MD</u>	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Bryan W. Clary</u>				34. NAME AND ADDRESS OF FACILITY <u>Lemmon Funeral Home</u> <u>10 W. Padonia Road, Timonium, MD 21093</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>RESPIRATORY ARREST</u>							
DUE TO (OR AS A CONSEQUENCE OF): <u>PONTINE CEREBROVASCULAR</u>							
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>ACCIDENT</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
35. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				36. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		37. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
38. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
40. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		41. DATE OF INJURY (Month, Day, Year)		42. TIME OF INJURY <u>M</u>		43. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				45. DESCRIBE HOW INJURY OCCURRED			
46. LOCATION (Street and Number or Rural Route Number, City or Town, State)				47. DATE SIGNED (Month, Day, Year) <u>3/4/96</u>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Heaven B. Chen M.D.</u>				29c. LICENSE NUMBER <u>P21680</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>6717 Park Heights Ave. 21215</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 07 1996</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

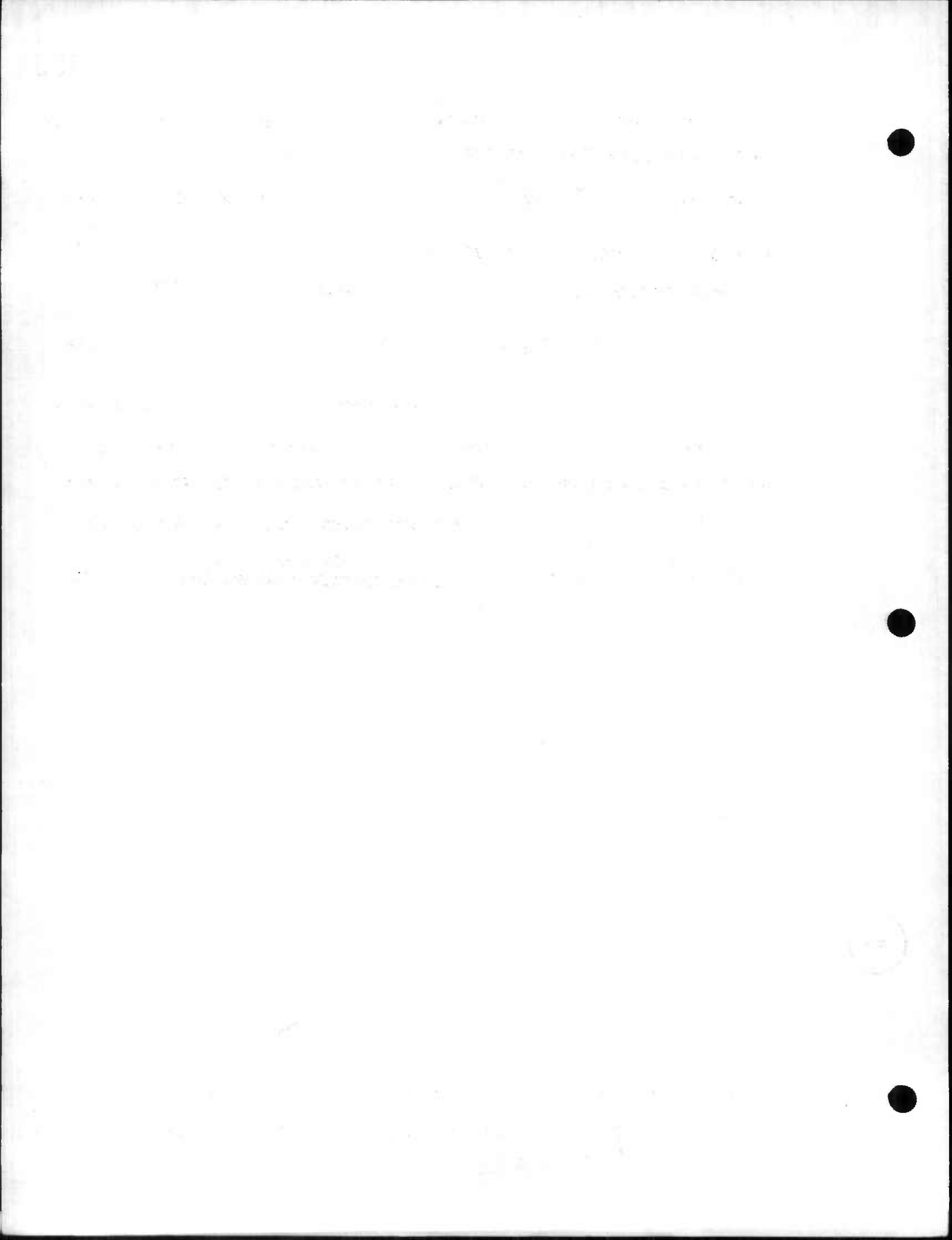
State of Maryland / Department of Health and Mental Hygiene

96 06635

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHARINE COHEN				2. Date of Death Month FEB. Day 20, Year 1996				3. Time of Death 8:45pm	
	4a. Facility Name (If not institution, give street and number) 7111 PARK HEIGHTS AVE., APT. 304				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-07-8356		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) JULY 14, 1912		9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 7111 PARK HEIGHTS AVE., APT. 304		10f. Zip Code 21215		10g. Citizen of What Country? USA		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry NATIONAL PAPER CO.		17. Father's Name (First, Middle, Last) MOSES COHEN		18. Mother's Name (First, Middle, Maiden Surname) BEATRICE ROSENFELD		19a. Informant's Name/Relationship (Type, Print) MRS. NANCY GERTNER (ATTORNEY)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. CALVERT ST, SUITE 708 BALTIMORE, MD 21202	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP		Data 3-5-1996		20c. Location - City or Town, State TOWSON, MD		21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>	
Physician /Medical Examiner	22. Name and Address of Facility SOL LEVINSON & BROS., INC.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Cornea Due to (or as a consequence of): b. Hepatic failure & coagulopathy Due to (or as a consequence of): c. Post-Breast Ca Due to (or as a consequence of): d. Post Lung Ca		Approximate Interval Between Onset and Death 36 hr. 2 mo. 6 yr. 11 yr.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael A. Kearney MD</i>	
	29c. License number D-76254		29d. Date signed (Month, Day, Year) FEB 21, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no above		31. Data filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature <i>John Davidson-Randall</i>	



96 06636

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) platt Walker Covington				2. DATE OF DEATH MONTH DAY YEAR March 05, 1996		3. TIME OF DEATH 8:25 p. M	
4. SOCIAL SECURITY NUMBER 529-09-0905		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 10, 1920	
8. BIRTHPLACE (State or Foreign Country) Washington D.C.				9a. FACILITY NAME (If not institution, give street and number) 4100 North Charles Street Unit 903		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4100 North Charles Street Unit 903	
10f. ZIP CODE 21218-1025				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II, Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 03				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Engineer		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Platt Walker Covington, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rhea Wheat			
19a. INFORMANT'S NAME (Type/Print) Mrs. Janet B. Covington (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 North Charles Street Unit 903 Balto. Md. 21218			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Srevice Corp. 3/07/96		20c. LOCATION — City or Town, State Towson, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey L. Gair</i> Jeffrey L. Gair				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PANCREATIC CANCER							
DUE TO (OR AS A CONSEQUENCE OF): BONE AND LIVER METASTASES							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric J. Seifter</i> MD				29c. LICENSE NUMBER 29373		29d. DATE SIGNED (Month, Day, Year) 3/6/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERIC J. SEIFTER 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Robert</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06637

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Eugene Cooper</i>				2. Date of Death Month <i>March</i> Day <i>5</i> Year <i>1996</i>		3. Time of Death <i>7:40A</i>	
	4a. Facility Name (If not institution, give street and number) <i>Maryland General Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>214-40-9598</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>55</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>AUG. 27. 1940</i>	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent							
10a. State <i>MARYLAND</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE CITY</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>1431 E. PRESTON STREET</i>				10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7TH</i> College (1-4 or 5+) <i>N/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HANDYMAN</i>		16b. Kind of Business/Industry <i>SELF EMPLOYED</i>		
17. Father's Name (First, Middle, Last) <i>PHILLIP COOPER</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>JEAN WHITE</i>				
19a. Informant's Name/Relationship (Type, Print) <i>BARBARA JEAN STOKES</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2410 FLEETWOOD AVE. BALTO. MD. 21214</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT. ZION CEM. MARCH 8, 1996 BALTO, MD.</i>		Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs, Jr.</i>				22. Name and Address of Facility <i>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>AIDS Wasting Syndrome</i> Due to (or as a consequence of): b. <i>Acquired Immuno Deficiency Syndrome</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>1 Year more than 5 years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe Ecchymosis</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>None</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Robert Kent, MD</i>		29c. License number <i>DO6966</i>		29d. Date signed (Month, Day, Year) <i>March 6, 1996</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Robert Kent, MD 1001 N. Cathedral St. Baltimore 21201</i>								
31. Date filed (Month, Day, Year) <i>MAR 07 1996</i>				32. Registrar's Signature <i>John A. Anderson</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. In the second part, we shall consider the question of the influence of the external magnetic field on the atomic structure.

3. The third part of the paper is devoted to a discussion of the question of the influence of the external electric field on the atomic structure.

4. In the fourth part, we shall consider the question of the influence of the external magnetic field on the atomic structure.

5. The fifth part of the paper is devoted to a discussion of the question of the influence of the external electric field on the atomic structure.

6. In the sixth part, we shall consider the question of the influence of the external magnetic field on the atomic structure.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

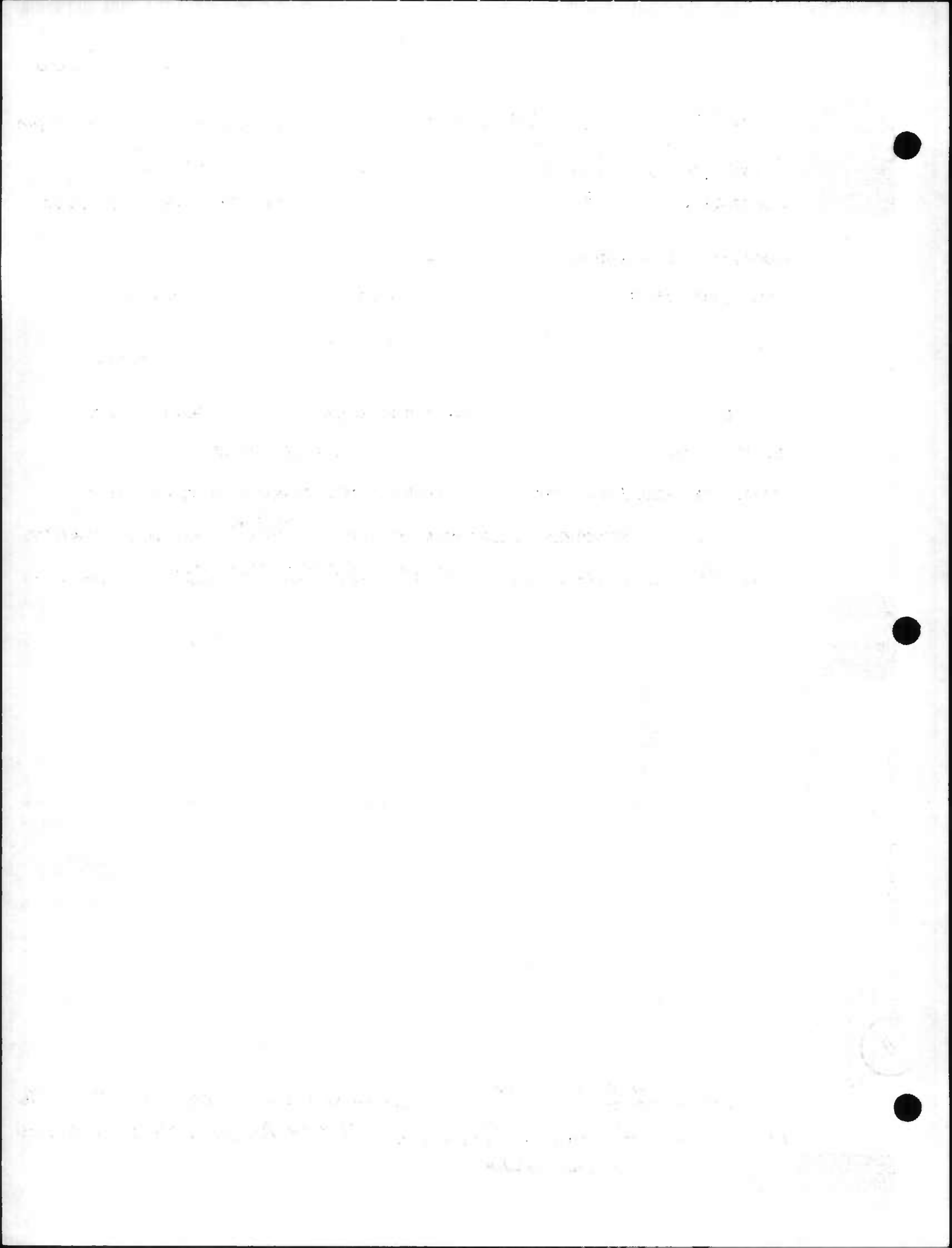
State of Maryland / Department of Health and Mental Hygiene

96 06638

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET v. DAILEY				2. Date of Death Month Day Year FEBRUARY 29 1996		3. Time of Death 11-15PM	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 216-07-4975		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 22, 1915	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location PASADENA	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1093 LOCUST DRIVE		10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINE OPERATOR		16b. Kind of Business/Industry MATCH COMPANY			
	17. Father's Name (First, Middle, Last) RAYMOND SHILOW				18. Mother's Name (First, Middle, Maiden Surname) LILLIAN MCKAY			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) LILLIAN KAMINSKI / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1093 LOCUST DRIVE, PASADENA, MARYLAND 21122			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date MARCH 4, 1996		20c. Location - City or Town, State BALTIMORE, MARYLAND	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	21. Signature of Funeral Service Licensee Anthony J. Dimas M00903				22. Name and Address of Facility LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NON-HODGKIN'S LYMPHOMA							Approximate Interval Between Onset and Death 1 MONTH
To Be Completed by Physician/Medical Examiner	23b. Due to (or as a consequence of):							
	23c. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	23d. Due to (or as a consequence of):							
	23e. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Yal Shira, MD.				29c. License number D46962		29d. Date signed (Month, Day, Year) FEBRUARY 29, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, MD. HOUSE PHYSICIAN. NORTH ARUNDEL HOSPITAL. MD 21061							
State Registrar	31. Date filed (Month, Day, Year) MAR 07 1996							
	32. Registrar's Signature Jahid...							



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN J. JAMES DORSEY				2. Date of Death Month MARCH Day 3 Year 1996		3. Time of Death 7:28 P.M.	
	4a. Facility Name (If not institution, give street and number) 336 PRESSTMAN STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-24-2159		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 11, 1930	
	9. Birthplace (State or Foreign Country) Baltimore		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 336 Presstman Street		10f. Zip Code 21217		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) Earl Dorsey	
	18. Mother's Name (First, Middle, Maiden Surname) Ella M. Wade		19a. Informant's Name/Relationship (Type, Print) Rosa Lee McCray		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1071 Ellicott Drive, Balto., MD 21216		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Date 3/9/96		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee Leroy O. Dyett	
	22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE BALTO. 21207		23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. FATTY LIVER Due to (or as a consequence of): ALCOHOLISM Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier Mario F. Golie Jr MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 4, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLIE JR MD 111 Penn Street, Baltimore, Maryland 21201	
State Registrar	31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature John Davidson-Randall		33. Date of Death (Month, Day, Year) MARCH 3, 1996		34. Time of Death 7:28 P.M.	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06640

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JERRI ANN DUPREE				2. Date of Death Month Day Year MARCH 6, 1996		3. Time of Death 7AM	
	4e. Facility Name (If not institution, give street and number) 5513 DAYWALT AVE.				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-54-7904	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 14, 1950		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 5513 DAYWALT AVE.		10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (14 or 5+) 2 YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK TYPIST		16b. Kind of Business/Industry BALTIMORE CITY			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) NATHAN THOMAS				18. Mother's Name (First, Middle, Maiden Surname) GERALDINE JONES			
	19a. Informant's Name/Relationship (Type, Print) KAREN MYERS - SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 DAYWALT AVE. BALTO, MD. 21206			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VET. CEM		20c. Date MARCH 8, 1996		20d. Location - City or Town, State OWINGS MILLS, MD.	
	21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs Jr.</i>		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Bacteremia - pseudomonas</i> Due to (or as a consequence of): b. <i>myopathy/polyrathulopathy lower extremities</i> Due to (or as a consequence of): c. <i>Aids Human immunus virus</i> Due to (or as a consequence of): d. <i>Retinal vessel se chronic hyper tension</i>							Approximate Interval Between Onset and Death <i>2/11/96</i> <i>7/95</i> <i>6/95 5/96</i> <i>7/95</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Alan Cross MD</i>		29c. License number D 20709		29d. Date signed (Month, Day, Year) MARCH 6, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Cross MD Baltimore JACC - ID Clinic								
31. Date filed (Month, Day, Year) MAR 07 1996								
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

10 f1

96 06641

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TRUDIE H. FAYE				2. DATE OF DEATH MONTH 03 DAY 04 YEAR 96		3. TIME OF DEATH 5:46 A M	
4. SOCIAL SECURITY NUMBER 216-34-2418		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-28-02	
9a. FACILITY NAME (If not institution, give street and number) Harbour Inn Conc. Ctr 1213 Light St Baltimore				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a	
10a. STATE MD.		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1619 N. CARROLLTON AVENUE				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 th College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWORK		16b. KIND OF BUSINESS/INDUSTRY private home			
17. FATHER'S NAME (First, Middle, Last) unk.				16. MOTHER'S NAME (First, Middle, Maiden Surname) SAWYER			
19a. INFORMANT'S NAME (Type/Print) ANNIE MARIE SPENCER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUTE 1, BOX 169, COLUMBIA, NC 27925			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NATIONAL 3-8		20c. LOCATION — City or Town, State LAUREL, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Malnutrition & Renal Failure TRUE TO (OR AS A CONSEQUENCE OF): Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 6 months 1 1/2 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fredrick Sirkis M.D.</i>				29c. LICENSE NUMBER D22645		29d. DATE SIGNED (Month, Day, Year) 3/4/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDRICK SIRKIS M.D. 751 HOLABIRD AVE. BALTO. MD. 21222							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14001 02

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06642

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frederick A. Geist

2. Date of Death

Month
Feb.Day
29Year
1996

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

13342 Elliott Drive

4b. City, Town, or Location of Death

Clarksville

4c. County of Death

Howard

5. Social Security Number

127-20-1087

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 23, 1927

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Clarksville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13342 Elliott Drive

10f. Zip Code

21029

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Bottle
Manufacturing Company

17. Father's Name (First, Middle, Last)

Frederick A. Geist

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Weinmann

19a. Informant's Name/Relationship (Type, Print)

Karen Palazzolo (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13342 Elliott Drive, Clarksville, MD 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Patrick's Cem.

Date

Mar. 5, 1996

20c. Location - City or Town, State

Gallitzin, PA

21. Signature of Funeral Service Licensee

R. Craig Witzke Jr.

22. Name and Address of Facility

Leroy M & Russell C Witzke Funeral Home
5555 Twin Knolls Rd. Columbia, MD 2104523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic cancer undetermined site. 6 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)
N/A28b. Time of
Injury
N/A M28c. Injury at
Work?
N/A
1 ☐ Yes 2 ☐ No28d. Describe how injury occurred
N/A28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)
N/A28f. Location (Street and Number or Rural Route Number,
City or Town, State)
N/A29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

R. Craig Witzke Jr. MD

29c. License number

D 41139

29d. Date signed (Month, Day, Year)

2/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11065 Little Potomac Parkway, Columbia, MD

31. Date filed (Month, Day, Year)

MAR 07 1996

32. Registrar's Signature

Julia Shuster-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
5026.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06643

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Elizabeth Heffernan				2. Date of Death Month Day Year March 5, 1996		3. Time of Death 9:45 PM										
	4a. Facility Name (If not Institution, give street and number) Manor Care Ruxton				4b. City, Town, or Location of Death Towson		4c. County of Death BALTIMORE										
Funeral Director	5. Social Security Number 336-12-0841		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 22, 1922										
	9. Birthplace (State or Foreign Country) ILLINOIS		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location SPARKS										
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6 Victoria Falls Drive		10f. Zip Code 21152		10g. Citizen of What Country? USA										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home												
	17. Father's Name (First, Middle, Last) Owen O'Malley				18. Mother's Name (First, Middle, Maiden Surname) Bridget Hopkins												
	19a. Informant's Name/Relationship (Type, Print) William R. Heffernan				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Victoria Falls Drive, Sparks, MD 21152												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens MARCH		20c. Location - City or Town, State Timonium, MD												
	21. Signature of Funeral Service Licensee Lowell M. Lemmon				22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. METABOLIC ENCEPHALOPATHY</td> <td>Approximate Interval Between Onset and Death 1 month</td> </tr> <tr> <td>b. CONGESTIVE HEART FAILURE</td> <td>1 year</td> </tr> <tr> <td>c. ISCHEMIC HEART DISEASE</td> <td>3 years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. METABOLIC ENCEPHALOPATHY	Approximate Interval Between Onset and Death 1 month	b. CONGESTIVE HEART FAILURE	1 year	c. ISCHEMIC HEART DISEASE	3 years	d.	
	Immediate Cause (Final disease or condition resulting in death)	a. METABOLIC ENCEPHALOPATHY	Approximate Interval Between Onset and Death 1 month														
b. CONGESTIVE HEART FAILURE		1 year															
c. ISCHEMIC HEART DISEASE		3 years															
d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
<table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier Richard J. Gross, M.D.				29c. License number 018758		29d. Date signed (Month, Day, Year) 3/6/96											
30. Name and address of person who completed cause of death (item 23e) (Type, Print) Richard J. Gross, M.D., 20 E. Timonium Rd., Suite 30, Timonium, MD 21093																	
31. Date filed (Month, Day, Year) JAN 26 1996																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

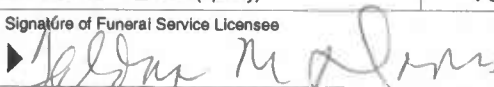


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06644

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LENA MAE HYMAN				2. Date of Death Month Day Year MARCH 4, 1996		3. Time of Death 6:35 a		
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a		
Funeral Director	5. Social Security Number 213-54-2663	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) SEPT. 2, 1945		9. Birthplace (State or Foreign Country) N. CAROLINA	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County n/a	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 2333 MILLIMAN STREET			10f. Zip Code 21205		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input checked="" type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 th College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSING LABORER		16b. Kind of Business/Industry MAINTENANCE				
	17. Father's Name (First, Middle, Last) ROY LEE HYMAN			18. Mother's Name (First, Middle, Maiden Surname) LUCY KNIGHT					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) VANESSA HY,MAN -daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2333 MILLIMAN STREET, BALTIMORE, MD 21205					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS 3-8		20c. Location - City or Town, State DUNDALK, MD				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility WM. C. MARCH FH.-1101 E. NORTH AVENUE					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. Aspiration - Due to (or as a consequence of): b. Spontaneous Bacterial Peritonitis Due to (or as a consequence of): c. Hepatic Cirrhosis Due to (or as a consequence of): d. Alcohol Abuse							6 hours 2 weeks 6 months 10 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Staphylococcal Aureus Endocarditis - Gastritis -						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number N2624		29d. Date signed (Month, Day, Year) March, 4, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin H. Teichon, Johns Hopkins Hospital, Baltimore Maryland									
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Z

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06645

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NINA HENRY		2. Date of Death Month Day Year MARCH 03, 1996		3. Time of Death 0805 AM
	4a. Facility Name (If not institution, give street and number) 1512 EAST MADISON STREET		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 237-42-8141	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	8. Date of Birth (Month, Day, Year) 9-10-29	9. Birthplace (State or Foreign Country) N.C.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 1512 E. Madison ST.		10f. Zip Code 21205		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry HOUSE		
	17. Father's Name (First, Middle, Last) Oliver Patterson		18. Mother's Name (First, Middle, Maiden Surname) Lillian Byers		
	19a. Informant's Name/Relationship (Type, Print) Marilyn Young		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 E. Madison ST Baltimore, Md. 21205		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Zion Cemetery		20c. Location - City or Town, State 3-7-96 Baltimore, Md
Physician /Medical Examiner	21. Signature of Funeral Service Licensee John B. Johnson		22. Name and Address of Facility DERRICK C. JONES Funeral Home 4611 Park Heights Ave		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier Ann Dixon M.D.		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 03, 1996
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature John B. Johnson			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ITEM: 82. PER F.H. FILM G-733 3/7/96 t.t

96 06646

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jerome Harris				2. DATE OF DEATH MONTH MAR DAY 3 YEAR 1996		3. TIME OF DEATH 6:00 P.M.	
4. SOCIAL SECURITY NUMBER 213-07-1503		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUL 4, 1911	
8a. FACILITY NAME (If not institution, give street and number) CHURCH HOME HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 201 N. BROADWAY APT. 9J				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 th College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHAUFFER		16b. KIND OF BUSINESS/INDUSTRY PRIVATE DUTY	
17. FATHER'S NAME (First, Middle, Last) ARTHUR HARRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) BIRDIE CARTER			
19a. INFORMANT'S NAME (Type/Print) MARGARET LINDSEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 E. CHASE STREET, BALTIMORE, MD 21213			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHILL MEMORIAL GARDENS 3-8 DUNDALK, MD		20c. LOCATION — City or Town, State		DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY MARCH WM. C. MARCE - 1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cancer metastatic to liver DUE TO (OR AS A CONSEQUENCE OF): b. cancer, unknown primary DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death months months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER 28587		29d. DATE SIGNED (Month, Day, Year) MAR 3 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Gormley 900 Caton Ave Balt. MD 21229							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000000 000

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ITEM: 16, PER F.H. FILM G-733
3/7/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06647

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY HUDSON HARPER						2. Date of Death Month Day Year MARCH 5 1996		3. Time of Death 1:00 AM		
	4a. Facility Name (If not institution, give street and number) MANOR CARE RUXTON						4b. City, Town, or Location of Death RUXTON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 042-18-0526		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 16, 1914		9. Birthplace (State or Foreign Country) RHODE ISLAND		
	Usual Residence of Decedent										
10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location CARNEY				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 8941 WALTHAM WOODS RD.				10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS College (1-4 or 5+) 2 YRS				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY SECRETARY			16b. Kind of Business/Industry BALTD. PUBLIC SCHOOL				
17. Father's Name (First, Middle, Last) SAMUEL HUDSON						18. Mother's Name (First, Middle, Maiden Surname) RUTH HAWES					
19a. Informant's Name/Relationship (Type, Print) GAIL HOXSEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245 KENT PLACE BLVD SUMMIT, NJ. 07901							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY			20c. Date 3/7		20d. Location - City or Town, State BALTIMORE			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. 21234							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): ulcerative colitis Due to (or as a consequence of): ASCVD Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 2 weeks 4 yrs											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 							29c. License number 042736	
			29d. Date signed (Month, Day, Year) 3-6-96								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AYMAN F. AKKAD 7600 OSLER DRIVE S-203 TOWSON MD.											
31. Date filed (Month, Day, Year) MAR 07 1996			32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06648

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOANNE MARIE HIEATZMAN

2. Date of Death

Month Day Year
MARCH 04 1996

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

RTE. 108 & SUNDOWN ROAD

4b. City, Town, or Location of Death

WASTONSVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

213-72-1890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 3, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7219 Patton Drive

10f. Zip Code

21797

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bakery Supervisor

16b. Kind of Business/Industry

Giant Food Store

17. Father's Name (First, Middle, Last)

William Griffith

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane MacKessy

19a. Informant's Name/Relationship (Type, Print)

Reed Hieatzman (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7219 Patton Drive Woodbine, Maryland 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. View Cemetery March 8, 1996

Date

20c. Location - City or Town, State

Marriottsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Leroy M & Russell C Witzke Funeral Homes
1630 Edmondson Avenue Catonsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HEAD INJURIES

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
3/4/96

28b. Time of Injury

0456 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject driver struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rte. 108 and Sundown Road in Montgomery County, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 05, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 07 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State
Registrar

96 06649

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jimmy Hill				2. DATE OF DEATH MONTH MARCH DAY 5 YEAR 1996		3. TIME OF DEATH 6 15 PM	
4. SOCIAL SECURITY NUMBER 061-36-1220		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 27 1944	
9a. FACILITY NAME (If not institution, give street and number) Levin Dale Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
10a. STATE MD		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 703 LENNOX STREET				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+H College (14 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown		16b. KIND OF BUSINESS/INDUSTRY Gas + Electric of NY.			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Hill			
19a. INFORMANT'S NAME (Type/Print) Betty J. Hill				19b. MAILING ADDRESS (Street and Number or Rural Route Number—City or Town, State, Zip Code) 703 LENNOX STREET Balto. Md. 21217			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Singleton Cemetery 3/11/96		20c. LOCATION — City or Town, State Bladenboro N.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Glenn B. Starnes				22. NAME AND ADDRESS OF FACILITY March Funeral Home - West 4300 Wabash Ave. Balto. Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute cardio-pulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): b. atherosclerotic cardiac disease DUE TO (OR AS A CONSEQUENCE OF): c. uremia DUE TO (OR AS A CONSEQUENCE OF): d. chronic renal failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. anoxic encephalopathy decubiti, hepatitis C insulin dependent diabetes s/p above knee amputation (L)							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29a. SIGNATURE AND TITLE OF CERTIFIER Consuelo Alvarez				29b. LICENSE NUMBER D:44907		29c. DATE SIGNED (Month, Day, Year) March 6th 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Consuelo Alvarez 2434 W. Belvedere Ave Balto. Maryland 21215							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE Jab. Stinson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


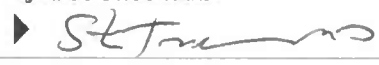
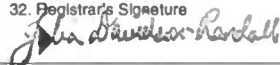
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06650

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine M. Hoerbelt					2. Date of Death Month Day Year February 9, 1996			3. Time of Death 4:20 AM.	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Nursing Home					4b. City, Town, or Location of Death Hyattsville			4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-22-0220		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) April 11, '08		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Hyattsville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 5805 Queens Road					10f. Zip Code 20782		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry At Home		
	17. Father's Name (First, Middle, Last) George Schmitt					18. Mother's Name (First, Middle, Maiden Surname) Katherine Ludwig				
	19a. Informant's Name/Relationship (Type, Print) Joan M. Mahoney					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9313 Davidson St., College Park, MD 20740				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Date 2-12-96		20d. Location - City or Town, State Suitland, MD		
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. Cardiopulmonary Arrest Due to (or as a consequence of):</p> <p>b. Aspiration Due to (or as a consequence of):</p> <p>c. Dementia Due to (or as a consequence of):</p> <p>d.</p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number D37934		29d. Date signed (Month, Day, Year) 2/9/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Trifoglio MD 7500 Greenway Center Drive Greenbelt MD 20770										
31. Date filed (Month, Day, Year) FEB 20 1996					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 06651

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM M. HENRY				2. Date of Death Month Day Year MAR 05 1996		3. Time of Death 10 28 PM	
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 219-10-3555		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR. 30, 1925	9. Birthplace (State or Foreign Country) Illinois
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Howard	10c. City, Town or Location Columbia			10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 5036 Lake Circle West				10f. Zip Code 21044		10g. Citizen of What Country? USA	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor			16b. Kind of Business/Industry College		
	17. Father's Name (First, Middle, Last) Don Henry				18. Mother's Name (First, Middle, Maiden Surname) Ethel Schwartz			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joan Henry (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5036 Lake Circle West, Columbia, MD 21044			
	20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Data Mar. 6, 1996	20c. Location - City or Town, State Catonsville, MD		
	21. Signature of Funeral Service Licensee R. A. Witzke				22. Name and Address of Facility Leroy M & Russell C Witzke Funeral Home 5555 Twin Knolls Rd., Columbia, MD 21045			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death Immediate DAY OF DEATH YEARS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 <input checked="" type="checkbox"/> Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier H. A. Oken		29c. License number D31172		29d. Date signed (Month, Day, Year) MARCH 5, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry A. Oken, MD 3460 Elliott Center Dr. Elliott City, MD 21043								
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature J. B. [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

96 06652

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JASON EDWARD JONES				2. Date of Death Month Day Year FEB. 28 1996		3. Time of Death 03:20 AM	
	4a. Facility Name (If not institution, give street and number) 8523 LUCERNE				4b. City, Town, or Location of Death Randallstown		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-04-4572	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 30, 1974		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Randallstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 8523 Lucerne Road			10f. Zip Code 21133		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) None		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed			16b. Kind of Business/Industry None		
	17. Father's Name (First, Middle, Last) Harry E. Jones				18. Mother's Name (First, Middle, Maiden Surname) Julia Delores Ryce			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. & Mrs. Harry Jones				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8523 Lucerne Rd. Randallstown, Md. 21133			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 3/4/96 Woodlawn, Md.		20d. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights Ave Balto. Md 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gun shot wound to Face Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2-27-96		28b. Time of Injury 2133M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 28, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

96 06653

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELLIE L. KNOX					2. Date of Death Month MARCH Day 5 Year 1996		3. Time of Death 8:30 AM		
	4a. Facility Name (If not institution, give street and number) 220B WILLIAMS ROAD					4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 212-28-1421		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) JAN. 12, 1910		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 220B WILLIAMS ROAD				10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) HARRY ROLAND GILBERT					18. Mother's Name (First, Middle, Maiden Surname) GEORGIA GILBERT				
	19a. Informant's Name/Relationship (Type, Print) LILLIAN RICHARDSON / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220B WILLIAMS ROAD, GLEN BURNIE, MARYLAND 21061					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date MARCH 7, 1996		20c. Location - City or Town, State BALTIMORE, MARYLAND			
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MO0877				22. Name and Address of Facility LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BRONCHOGENIC CARCINOMA. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death TWO YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>[Signature]</i> DR. DHARMASENA			29c. License number D17753		29d. Date signed (Month, Day, Year) MARCH 6, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DHARMASENA, 710 CHURCH STREET, BALTIMORE, MARYLAND 21225										
31. Date filed (Month, Day, Year) MAR 07 1996			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06654

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Vincent Keegan				2. Date of Death Month Day Year March 4 1996		3. Time of Death 02:35 PM	
	4a. Facility Name (If not institution, give street and number) Charlestown Care Center				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-10-6040		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 20, 1916	9. Birthplace (State or Foreign Country) Canada
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6028 Black Friars Circle				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technical Writer		16b. Kind of Business/Industry Westinghouse			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John A. Keegan				18. Mother's Name (First, Middle, Maiden Surname) Mildred Guy			
	19a. Informant's Name/Relationship (Type, Print) Madalyn Keegan (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 6028 Black Friars Circle Catonsville, Maryland			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date March 7, 1996	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of):							4 days
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cerebrovascular Accidents Due to (or as a consequence of):							
	c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
To Be Completed by Hospital or Attending Physician	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D34053		29d. Date signed (Month, Day, Year) March 4, 1996	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Applebaum MD 701 Myrtle Chase Lane 21228							
	31. Date filed (Month, Day, Year) MAR 0 7 1996				32. Registrar's Signature 			

147-2740

ITEM: 18. PER F.H. FILM
G-733 3/7/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06655

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NATHAN KIRSZENBAUM				2. Date of Death Month MARCH Day 03 Year 1996		3. Time of Death 7:39 AM	
	4a. Facility Name (If not institution, give street and number) 11791 TRIDELPHIA ROAD				4b. City, Town, or Location of Death WEST FRIENDSHIP		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 217-40-4176		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 3, 1923	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) POLAND					
To Be Completed by Funeral Director	10a. State MD		10b. County HOWARD		10c. City, Town or Location ELLCOTT CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 11791-A TRIDELPHIA ROAD				10f. Zip Code 21042		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) 8 Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAILOR		16b. Kind of Business/Industry CLOTHING			
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) ABRAHAM KIRSZENBAUM				18. Mother's Name (First, Middle, Maiden Surname) CHAVA LEIDA			
	19a. Informant's Name/Relationship (Type, Print) LEON KIRSZENBAUM				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11791-A TRIDELPHIA RD; ELLCOTT CITY, MD 21042			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI		20c. Date 3/6/96		20d. Location - City or Town, State OWINGS MILLS, MD	
	21. Signature of Funeral Service Director 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD; BALTIMORE, MD 21215			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUND OF HEAD, CONTACT Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) 3/3/96		28b. Time of Injury OTIS A.M.		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT SHOT SELF	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1179 TRIDELPHIA RD, WEST FRIENDSHIP			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 04, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARD F. GOULET JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06656

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Irvin H. Kinton</i>				2. Date of Death Month <i>March</i> Day <i>2</i> Year <i>1996</i>		3. Time of Death <i>8:PM</i>						
	4a. Facility Name (If not institution, give street and number) <i>8100 Derby Lane</i>				4b. City, Town, or Location of Death <i>Owings Mills</i>		4c. County of Death <i>Balto</i>						
Funeral Director	5. Social Security Number <i>238-46-0320</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>63</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Dec 31, 1932</i>	9. Birthplace (State or Foreign Country) <i>N.C.</i>					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State <i>md</i>		10b. County <i>Balto</i>		10c. City, Town or Location <i>Owings Mills</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number <i>8100 Derby Lane</i>				10f. Zip Code <i>21117</i>		10g. Citizen of What Country? <i>U.S.A</i>						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>4 yrs</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Engineer</i>		16b. Kind of Business/Industry <i>Lockheed Martin</i>								
	17. Father's Name (First, Middle, Last) <i>Irvin H. Kinton, Sr</i>				18. Mother's Name (First, Middle, Maiden Summa) <i>Margaret Scott</i>								
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Mary Kinton</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21117</i> <i>8100 Derby Lane Owings Mills, md</i>								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		Date <i>3-9-96</i>		20c. Location - City or Town, State <i>Catonsville, md</i>						
	21. Signature of Funeral Service Licensee <i>Bladner Wane</i>				22. Name and Address of Facility <i>March F. H. West 4300 Uabash Avenue Balto, md 21215</i>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>liver failure</i> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <i>6-9 months</i></td> </tr> <tr> <td>b. <i>metastatic squamous cell carcinoma</i> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <i>laryngeal cancer</i> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>liver failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>6-9 months</i>	b. <i>metastatic squamous cell carcinoma</i> Due to (or as a consequence of):	c. <i>laryngeal cancer</i> Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <i>liver failure</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>6-9 months</i>											
	b. <i>metastatic squamous cell carcinoma</i> Due to (or as a consequence of):												
	c. <i>laryngeal cancer</i> Due to (or as a consequence of):												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ernest Sneed, MD</i>		29c. License number <i>046039</i>		29d. Date signed (Month, Day, Year) <i>3/5/96</i>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>3527 ROLLING ROAD #4 BALTIMORE MD 21207</i>													
31. Date filed (Month, Day, Year) <i>MAR 07 1996</i>		32. Registrar's Signature <i>John [Signature]</i>											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06657

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNIE MAE LLOYD				2. DATE OF DEATH MONTH DAY YEAR March 2, 1996		3. TIME OF DEATH 6:15 P M	
4. SOCIAL SECURITY NUMBER 490-56-3496		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun. 20, 1895	
9a. FACILITY NAME (If not institution, give street and number) 1304 Edison Highway				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1304 Edison Highway			
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16. KIND OF BUSINESS/INDUSTRY School			
17. FATHER'S NAME (First, Middle, Last) Albert Carter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charolette Carter			
19a. INFORMANT'S NAME (Type/Print) Ruth Trapp				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Edison Highway, Baltimore, MD 21213			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pheba Cemetery		20c. LOCATION — City or Town, State Pheba, Mississippi		DATE 3-6	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley K. Jones</i>				22. NAME AND ADDRESS OF FACILITY March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1-2 days 4-5 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann Marie Jones, MD</i>				29c. LICENSE NUMBER D43136		29d. DATE SIGNED (Month, Day, Year) 3/5/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SSDS HOPKINS BAYVIEW CIRCLE BALTIMORE MD. 21212							
31. DATE FILED (Month, Day, Year) MAR 07 1996		32. REGISTRAR'S SIGNATURE <i>Jane D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06658

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK JOSEPH LINARDI				2. DATE OF DEATH MONTH Mar DAY 2 YEAR 1996		3. TIME OF DEATH 10:45 am	
4. SOCIAL SECURITY NUMBER 219-10-4805		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 30 1923	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION PARKVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2431 WOODROFT ROAD				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ABSENT		16b. KIND OF BUSINESS/INDUSTRY LIFE INSURANCE			
17. FATHER'S NAME (First, Middle, Last) Leo Linardi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Vicchio			
19a. INFORMANT'S NAME (Type/Print) MARGARET E. LINARDI				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2431 WOODROFT ROAD PARKVILLE MARYLAND 21234			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY 3-96		20c. LOCATION — City or Town, State Baltimore Maryland		20d. DATE 3-96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL - Bldg. A, P.A. 31 NEWPORT DRIVE, FOREST HILL, MD. 21030			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EMBOLISM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ALZHEIMER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 2 DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER BR 2116069		29d. DATE SIGNED (Month, Day, Year) 3/2/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL BO. M.D. 7620 YORK RD., TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) MAR 0 7 1996				REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM RONALD MALONE				2. Date of Death Month Day Year FEBRUARY 26 1996		3. Time of Death 7:15 AM			
	4e. Facility Name (If not institution, give street and number) 1905 PINEWAY				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO			
Funeral Director	5. Social Security Number 219-46-4289		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/21/49	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1905 Pineway				10f. Zip Code 21801		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 0				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine operator		16b. Kind of Business/Industry E.I. Dupont Co.				
17. Father's Name (First, Middle, Last) William Calvin Malone				18. Mother's Name (First, Middle, Maiden Surname) Gladys Helen Niblett						
19a. Informant's Name/Relationship (Type, Print) Deborah Ann Malone				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Pineway, Salisbury, MD 21801						
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		Date 3/1/96		20c. Location - City or Town, State Hebron, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 27, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 04 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

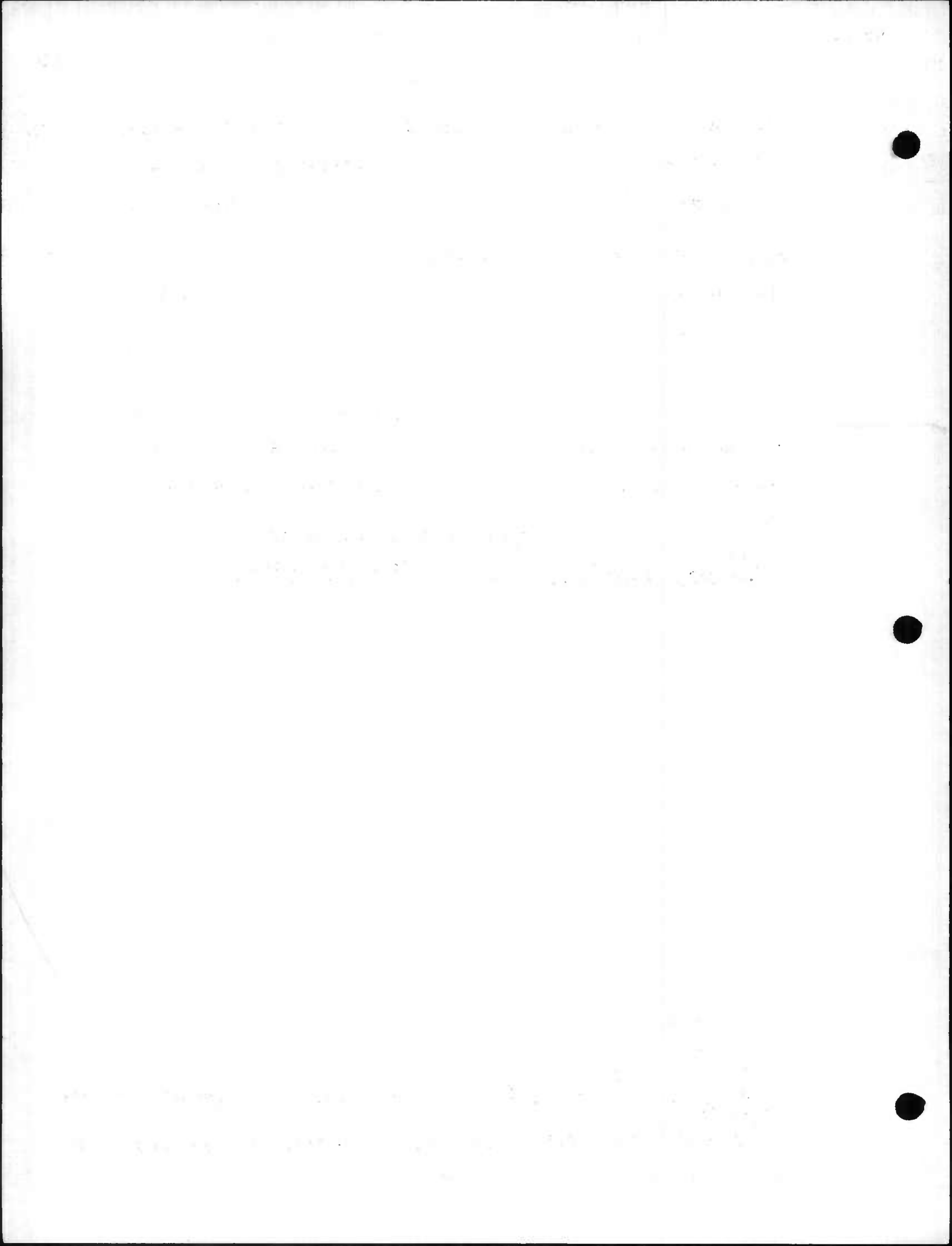
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

State Registrar



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl S Miller				2. Date of Death March 3, 1996 Year		3. Time of Death 11:30 pm	
	4a. Facility Name (If not institution, give street and number) 6 STONEHENGE Circle #8 21208				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-46-0267		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 2, 1910	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 6 STONEHENGE Circle #8				10f. Zip Code 21208		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Morris Shapos				18. Mother's Name (First, Middle, Maiden Surname) Molly Caplan				
19a. Informant's Name/Relationship (Type, Print) William S. Miller (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 STONEHENGE Cir #6 Baltimore MD 21208				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oheb Shalom Cem.		Date March 4, 1996		20c. Location - City or Town, State Reisterstown MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Endometrial Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Fouad M. Abbas M.D.		29c. License number D38972		29d. Date signed (Month, Day, Year) March, 4th 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOUAD ABBAS % SINAI HOSPITAL - BALTIMORE, MD								
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature John Davidson Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Item 24a, thru 29a, Film 733, 3/6/96, Per Doc, Lt

Certificate of Death

Reg. No.

96 06661

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Florence B. Lehman		2. Date of Death Month Day Year February 8, 1996		3. Time of Death 4:45 P.M.	
4a. Facility Name (If not institution, give street and number) Montgomery General Hospital		4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
5. Social Security Number 012-16-1783	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Massachusetts	
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. Street and Number 531 Norwood Road		10f. Zip Code 20905		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Journalist		16b. Kind of Business/Industry Newspapers	
17. Father's Name (First, Middle, Last) Frank Arthur Barrett		18. Mother's Name (First, Middle, Maiden Surname) Florence Virginia Crouse			
19a. Informant's Name/Relationship (Type, Print) James E. Lehman, Jr., Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 Sundown Road, Laytonsville, Maryland 20882			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee Muriel H. Barber		22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 P. O. Box 5038, Laytonsville, Maryland			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. UREMIA Due to (or as a consequence of): b. PROSEPTIS Due to (or as a consequence of): c. CHRONIC RENAL FAILURE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death ONE WEEK ONE WEEK TEN YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Thomas E. Dooley M.D.		29c. License number D16458		29d. Date signed (Month, Day, Year) Feb 9, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Dooley, M.D. 17904 Georgia Avenue, Olney, Maryland 20832					
31. Date filed (Month, Day, Year) MAR 06 1996		32. Registrar's Signature John A. Randall			

96 06662

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Priscilla A. Marcus				2. DATE OF DEATH MONTH 3 DAY 2 YEAR 96		3. TIME OF DEATH 8:50 P M	
4. SOCIAL SECURITY NUMBER 219 281961		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 79 DAYS 79	IF UNDER 24 HRS. HOURS 79 MIN. 79	7. DATE OF BIRTH (Month, Day, Year) 6-24-16	
8a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Geriatric Center				8b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8c. COUNTY OF DEATH Baltimore City	
9. RESIDENCE OF DECEDENT				10a. STATE MD		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 430 E. 23 rd street	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10 th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DAYCARE PROVIDER		16b. KIND OF BUSINESS/INDUSTRY in own home			
17. FATHER'S NAME (First, Middle, Last) SAMUEL EVANS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ANN MC GEE			
19a. INFORMANT'S NAME (Type/Print) MINNIE D. RUCKER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 430 E. 23 RD ST., BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY 3-8		20c. LOCATION — City or Town, State ANNE ARUNDEL CO, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration DUE TO (OR AS A CONSEQUENCE OF): partial bowel obstruction DUE TO (OR AS A CONSEQUENCE OF): Ileal loop CRF DUE TO (OR AS A CONSEQUENCE OF): CRF, malnutrition, pressure ulcer, bladder ca., chronic diarrhea, anemia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CRF, malnutrition, pressure ulcer, bladder ca., chronic diarrhea, anemia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D04383		29d. DATE SIGNED (Month, Day, Year) 3/4/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W.B. Greenough MD Johns Hopkins Geriatric, Balto MD							
31. DATE FILED (Month, Day, Year) MAR 6 7 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06663

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEONARD J MAKOWSKI				2. Date of Death Month MAR Day 6 Year 1996		3. Time of Death 633 AM	
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 219-18-4186		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	<input type="checkbox"/> Under 1 Year Months Days	<input type="checkbox"/> Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 7, 1928	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				10a. State MARYLAND		10b. County HOWARD	
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County HOWARD		10c. City, Town or Location ELLCOTT CITY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2913 CHESTNUT HILL DRIVE				10f. Zip Code 21043		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry NEWSPAPER COMPANY			
	17. Father's Name (First, Middle, Last) BENJAMIN MAKOWSKI				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE SIEMEK			
	19a. Informant's Name/Relationship (Type, Print) ANNA M. MAKOWSKI / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 CHESTNUT HILL DRIVE, ELLCOTT CITY, MD 21043			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date MAR. 8, 1996		20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee <i>Neil E. Kim</i> MO0877		22. Name and Address of Facility LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Ventricular fibrillation Due to (or as a consequence of): b. Arteriosclerotic cardiovascular Due to (or as a consequence of): c. disease Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Levan Kuck</i>		29c. License number 025004 MD		29d. Date signed (Month, Day, Year) MAR 6 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVAN KUCK, 5755 Cedar Avenue								
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature <i>John D. [Signature]</i>						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar
70

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) REBECCA MARSHALL		2. Date of Death Month Day Year MARCH 1 1996		3. Time of Death 5:40 AM
	4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death None
Funeral Director	5. Social Security Number 245-20-5748	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth Month Day Year MAY 10 1922	9. Birthplace (State or Foreign Country) Williamston, NC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md	10b. County None	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2703 E. Federal Street		10f. Zip Code 21213		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4or 5+) Unknown		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) James Outterbridge		18. Mother's Name (First, Middle, Maiden Surname) Betty Evetts		
	19a. Informant's Name/Relationship (Type, Print) HUSBAND Mr. Howard Marshall-father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 E. Federal St. Balto. Md. 21213		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 3/5/96 Woodlawn, Md
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Derrick C. Jones F.H. 4611 Park Heights Ave Balto. Md 21215		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death in line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. PULMONARY EMBOLISM Due to (or as a consequence of): BREAST CANCER		Approximate Interval Between Onset and Death 2 WEEKS 6 YEARS		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Viput Mantadilok		29c. License number P08217		29d. Date signed (Month, Day, Year) March 1, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIPUT MANTADILOK THE JOHNS HOPKINS HOSPITAL 660 NORTH WOLFE STREET BALTIMORE					
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature John A. Russell MD. 21267			

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 4a, PER F.H. FILM G-733

State of Maryland / Department of Health and Mental Hygiene

96 06665

3/7/96 t.t

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) J ISADORE LIPMAN				2. Date of Death Month MARCH Day 2 Year 1996		3. Time of Death 8⁰⁵ PM	
	4a. Facility Name (If not Institution, give street and number) NORTH Oaks				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-01-7837		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 5, 1907	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 725 Mount Wilson Lane Apt 401				10f. Zip Code 21208		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Investor		16b. Kind of Business/Industry Real Estate		
17. Father's Name (First, Middle, Last) Hyman Lipman				18. Mother's Name (First, Middle, Maiden Surname) Sarah Unknown				
19a. Informant's Name/Relationship (Type, Print) Dorothy Lipman (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Mount Wilson Lane Apt 401 Baltimore Md 21208				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Beth El Mem. Park		Date March 4, 1996		20c. Location - City or Town, State Randallstown Md		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Alzheimers Disease</u> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 7 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jay A. Lippman, MD						
		29c. License number D25001		29d. Date signed (Month, Day, Year) 3-3-96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAY A LIPPMAN MD 10085 Red Run Blvd Owings Mills MD 21117								
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible text covering the page]



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUCILLE MASSEY				2. DATE OF DEATH MONTH DAY YEAR MARCH 04 1996		3. TIME OF DEATH 5:05 A M	
4. SOCIAL SECURITY NUMBER 224-36-3701		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1925	
8. BIRTHPLACE (State or Foreign Country) VA				9. FACILITY NAME (If not institution, give street and number) Church Home Hospital			
10. CITY, TOWN OR LOCATION OF DEATH Baltimore				11. COUNTY OF DEATH n/a			
12. STATE MD		13. COUNTY Baltimore		14. CITY, TOWN OR LOCATION Turners Station		15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
16. STREET AND NUMBER 408 Maple Lane				17. ZIP CODE 21222		18. CITIZEN OF WHAT COUNTRY? USA	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: Black	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurses Assistant		25. KIND OF BUSINESS/INDUSTRY Health			
26. FATHER'S NAME (First, Middle, Last) Robert Rich				27. MOTHER'S NAME (First, Middle, Maiden Surname) Tina Tate			
28. INFORMANT'S NAME (Type/Print) David E. Massey				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Maple Lane Balto., MD 21222			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest 3/7		32. LOCATION — City or Town, State Owings Mills, MD			
33. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Manto				34. NAME AND ADDRESS OF FACILITY James H. Manto & Sons Funeral Home 1701 Laurens St. Balto. MD 21217			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPTIC SHOCK							
a. DUE TO (OR AS A CONSEQUENCE OF): MULTIPLE ORGAN FAILURE							
b. DUE TO (OR AS A CONSEQUENCE OF): PANCREATITIS							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
36. SEQUENTIALLY LIST CONDITIONS, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
38. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		40. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		41. DATE OF INJURY (Month, Day, Year)	
42. TIME OF INJURY M		43. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		44. DESCRIBE HOW INJURY OCCURRED			
45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				46. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
47. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER CV Bokhari MD				49. LICENSE NUMBER D-26594		50. DATE SIGNED (Month, Day, Year) March 04 1996	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RIAZ BOKHARI M.D. 100 North Broadway Baltimore, MD 21231							
52. DATE FILED (Month, Day, Year) MAR 07 1996				53. REGISTRAR'S SIGNATURE John Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000000 00

3/7/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06667

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORENZO R. NORRIS LORENZO RAYMOND NORRIS				2. Date of Death Month Day Year March 3 1996		3. Time of Death 9:25 p.m.	
	4a. Facility Name (If not institution, give street and number) DVA MEDICAL CENTER, FT. HOWARD, MD. 21052				4b. City, Town, or Location of Death Fort Howard		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-16-8215		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) April 3, 1918	
	9. Birthplace (State or Foreign Country) Baltimore, MD.		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location COCKEYSVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1054 Misty Lynn Circle		10f. Zip Code 21030		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 8-12-1941 9-26-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator		16b. Kind of Business/Industry Construction Industry			
	17. Father's Name (First, Middle, Last) John Norris				18. Mother's Name (First, Middle, Maiden Surname) Lillie Matthews			
	19a. Informant's Name/Relationship (Type, Print) Alice V. Norris				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1054 Misty Lynn Circle, Cockeysville, MD 21030			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery		Date 8 MARCH		20c. Location - City or Town, State Owings Mills, Md	
	21. Signature of Funeral Service Licensee Lowell M. Lemmon		22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd. Timonium, MD 21093					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple CVA's Due to (or as a consequence of): b. Prostate Cancer Due to (or as a consequence of): c. Atrial Fibrillation and CAD Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 11 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P Right AKA secondary to Peripheral Vascular Disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier [Signature]		29c. License number D30528		29d. Date signed (Month, Day, Year) March 3rd 1996.				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. DUGGIRALA, BALA M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052								
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OLGA PLITKO				2. DATE OF DEATH MONTH 03 DAY 05 YEAR 96		3. TIME OF DEATH 5:40 P.M.	
4. SOCIAL SECURITY NUMBER 215-30-4084		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-22-1905	
9a. FACILITY NAME (If not institution, give street and number) CATON MANOR NURSIN HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE CITY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lansdowne		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3180 Shiloh Ct.				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yr's College (1-4 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Karl Saar				16. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Unknown			
19a. INFORMANT'S NAME (Type/Print) Mr. Ulo Leius				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Clayton Ave. E. Atlantic Beach, N.Y. 11561			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 3/9/96		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. <i>Paul L. Hartsock Jr.</i>				22. NAME AND ADDRESS OF FACILITY Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CARDIAC ARREST					
		b. A.S.C.V.D.					
		c. HYPERTENSION					
		d. _____					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE GAIT APRAXIA							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>K. S. Dhar Masena, M.D.</i>				29c. LICENSE NUMBER D17753		29d. DATE SIGNED (Month, Day, Year) 3-6-1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. S. DHAR MASENA, M.D. 710 CHURCH ST. BALTO, MD 21225							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96-06669

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alicia Anna Reese

2. Date of Death

Month
MARCHDay
3Year
1996

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

4 VALLEY RIDGE CT.

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

119-18-1179

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 15, 1913

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

NEW YORK

10b. County

BRONX COUNTY

10c. City, Town or Location

NEW YORK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1579 METROPOLITAN AVE. APT. 2G

10f. Zip Code

10462

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6 yrs.

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JOHN P. DONOHUE

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET O'REILLY

19a. Informant's Name/Relationship (Type, Print)

SHEILA WHARAM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 VALLEY RIDGE COURT TIMONIUM, MARYLAND 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN

Date

3/7

20c. Location - City or Town, State

HAWTHORNE, NEW YORK

21. Signature of Funeral Service Licensee

Charles J. Evans Jr.

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
8800 HARFORD RD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive heart failure
Due to (or as a consequence of):
dilated cardiomyopathy

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic regurgitation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shelley E. Nolan

29c. License number

D33024

29d. Date signed (Month, Day, Year)

4/30/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Shelley E. Nolan 7505 Oster Dr. Baltimore 21204

31. Date filed (Month, Day, Year)

MAY 10 1996

32. Registrar's Signature

John A. Russell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

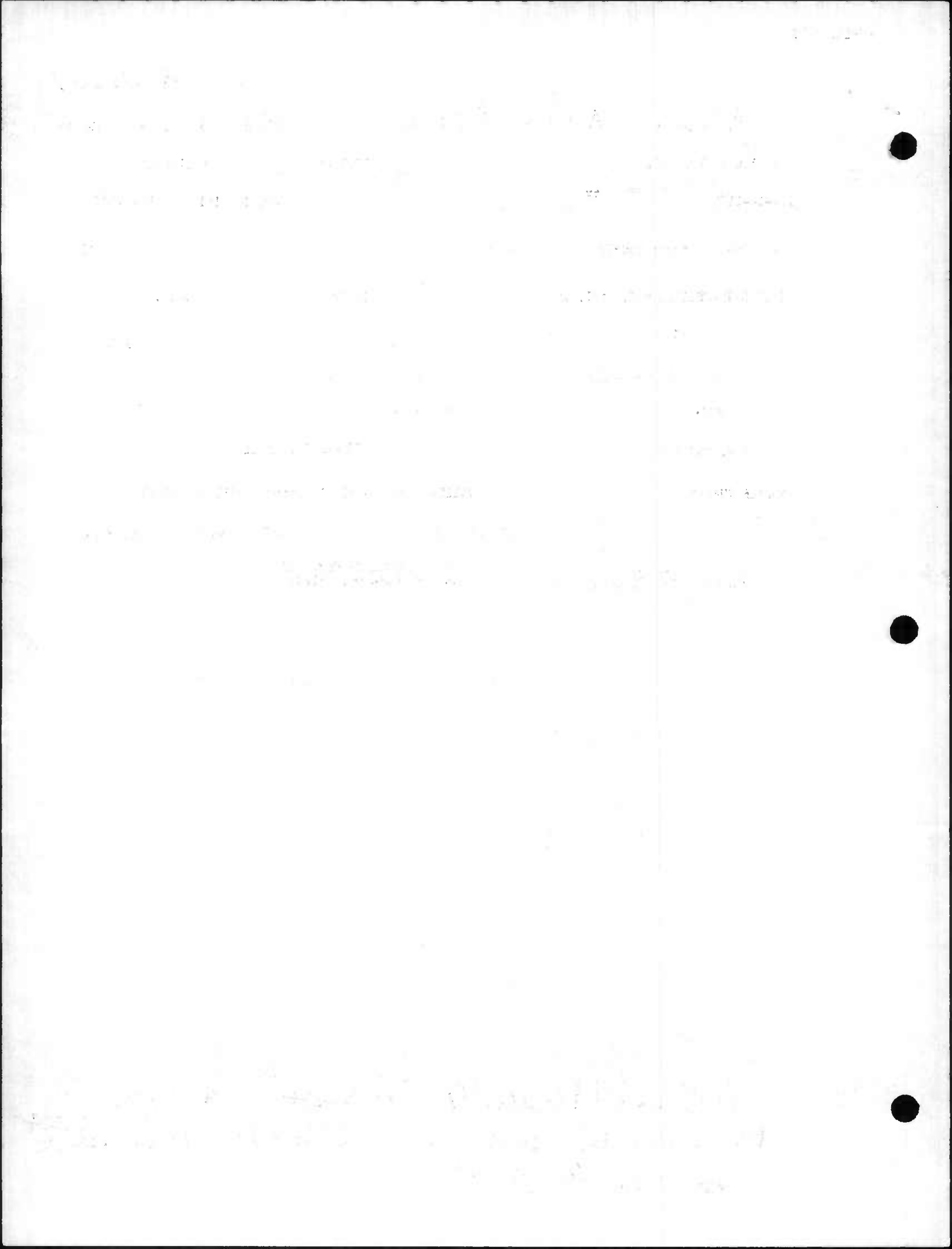
Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06670

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) MOON HO RO 2. Date of Death Month MARCH Day 3 Year 1996 3. Time of Death 8:30 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number) GENESIS ELDER CARE 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death

5. Social Security Number 21311 4036 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) 77 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) AUG 20, 1918 9. Birthplace (State or Foreign Country) SOUTH KOREA

Usual Residence of Decedent 10a. State MARYLAND 10b. County - 10c. City, Town or Location BALTIMORE 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 401 EAST 25TH STREET 10f. Zip Code 21218 10g. Citizen of What Country? SOUTH KOREA

11. Marital Status 1 ☐ Never Married ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9YRS. College (1-4 or 5+) - 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER 16b. Kind of Business/Industry DAE KWANG LUMBER CO.

17. Father's Name (First, Middle, Last) JAE HEE RO 18. Mother's Name (First, Middle, Maiden Surname) SOON SUNG LEE

19. Informant's Name/Relationship (Type, Print) Seunb B. Ro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 LERO BYRON LANE #103 LOCKSVILLE, MARYLAND 21030

20a. Method of Disposition ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY Date MARCH 5, 1996 20c. Location - City or Town, State TIMONIUM, MARYLAND

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONIUM

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic coronary artery disease

Due to (or as a consequence of): Hypertension Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 5 ☐ Pending Investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Marion Kowalewski M.D. 29c. License number 821022 29d. Date signed (Month, Day, Year) MARCH 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. MARION C. KOWALEWSKI, M.D. 8604 HARFORD ROAD, BALTIMORE, MD. 21234

31. Date filed (Month, Day, Year) MAR 07 1996 32. Registrar's Signature [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06671

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY RESNICK				2. Date of Death Month Day Year MAR. 3 1996		3. Time of Death 1:40 PM	
	4a. Facility Name (If not institution, give street and number) 3022 NORTHBROOK RD., APT. B				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214-20-4442		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 1 1908	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 3022 NORTHBROOK RD., APT. B				10f. Zip Code 21209		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR		16b. Kind of Business/Industry ANTIQUES		
17. Father's Name (First, Middle, Last) ADOLPH GOLDMAN				18. Mother's Name (First, Middle, Maiden Surname) ANNA HERMAN				
19e. Informant's Name/Relationship (Type, Print) JUDGE ALAN RESNICK (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6320 IVYMOUNT RD. BALTIMORE, MD 21209				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		Date 3/5/96		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimers Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last chronic measles infection Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death Years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Decerbitus ulcus chronic measles infection						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>S.H. MacInow</i>		29c. License number 004701		29d. Date signed (Month, Day, Year) 3/4/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.H. MACINOW MD 3635 Old Court Rd. Beltsville MD								
31. Date filed (Month, Day, Year) MAR 07 1996 <i>Julia [Signature]</i>								

112



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State of Maryland / Department of Health and Mental Hygiene

96 06672

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys O. Ringgold				2. Date of Death Month March Day 1st Year 1996		3. Time of Death 10:52am	
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Balto		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-18-1150		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 18, 1895	9. Birthplace (State or Foreign Country) Ind
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State md	10b. County N/A	10c. City, Town or Location Balto			10d. Inside-City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 19 N. Wheeler Ave				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Factory		
	17. Father's Name (First, Middle, Last) Daniel R. Dunn				18. Mother's Name (First, Middle, Maiden Surname) Clara Kell			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Daniel E. Ringgold				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2712 N. Longwood St. Balto, md 21216			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union United Methodist ch. Bldg.		20c. Location - City or Town, State 376/96 Aberdeen, md			
	21. Signature of Funeral Service Licensee W. Lander W. [unclear]				22. Name and Address of Facility March F. H. West 4300 Wabash Ave Balto, md 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Seizure disorder Due to (or as a consequence of): d. Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Kevin Elder MD Medical House		29c. License number D38993		29d. Date signed (Month, Day, Year) 03/01/96
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Elder MD 2600 Liberty Hgts Baltimore MD 21215								
31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature John [unclear]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

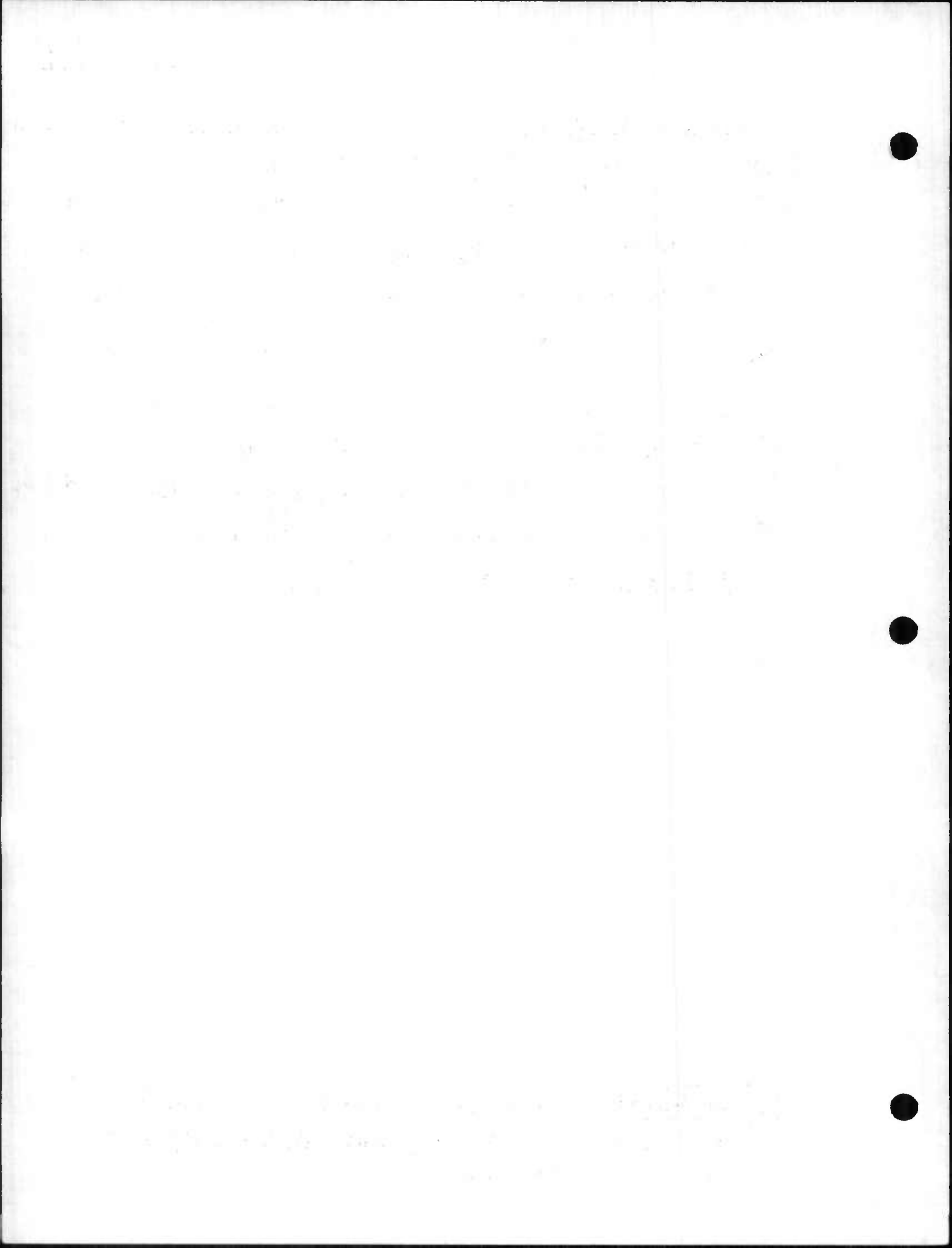
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06673

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN M. RINGGOLD				2. Date of Death Month 03 Day 04 Year 1996				3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) 461 MANSE COURT				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE, CITY	
Funeral Director	5. Social Security Number 214-22-4182		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 10/05/1912		9. Birthplace (State or Foreign Country) VIRGINIA	
	10a. State MARYLAND		10b. County BALTIMORE, CITY		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 461 MANSE COURT				10f. Zip Code 21201		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK				16b. Kind of Business/Industry SELF EMPLOYED			
	17. Father's Name (First, Middle, Last) BENJAMIN ROBERTS				18. Mother's Name (First, Middle, Maiden Surname) CARRIE ROBERTS					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MILTON B. RINGGOLD (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 PENTWOOD ROAD BALTO. MD. 21239					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEM. PARK 3/8/1996		Date 3/8/1996		20c. Location - City or Town, State ARBUTUS, MARYLAND			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME PA. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217					
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Respiratory Failure Due to (or as a consequence of):</p> <p>b. Pneumonia Due to (or as a consequence of):</p> <p>c. Chronic Lung Disease Due to (or as a consequence of):</p> <p>d. _____</p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D30942		29d. Date signed (Month, Day, Year) 3/7/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwen L. Dubois 5911 York Rd 21212										
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

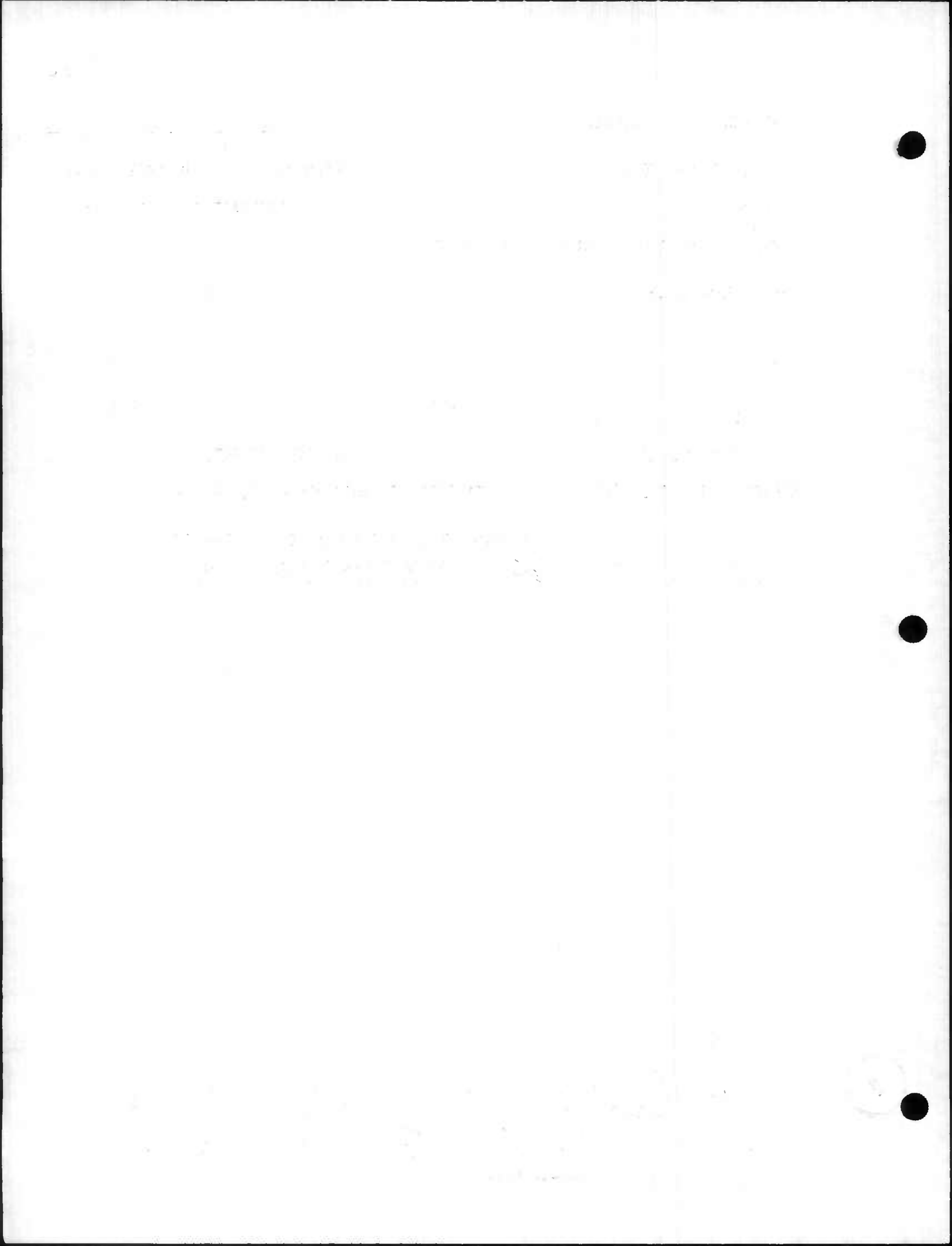
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06674

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL CHARLES SNYDER					2. Date of Death Month Day Year MARCH 1, 1996		3. Time of Death 6 AM		
	4a. Facility Name (If not institution, give street and number) 9 Tommy True Ct					4b. City, Town, or Location of Death PARKVILLE		4c. County of Death BALTO.		
Funeral Director	5. Social Security Number 213-70-3963		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) JULY 24, 1968		9. Birthplace (State or Foreign Country) MD.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County BALTO.		10c. City, Town or Location PARKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 9 Tommy True Ct				10f. Zip Code 21234		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) US NAVY E-5		16b. Kind of Business/Industry US ARMED FORCES			
	17. Father's Name (First, Middle, Last) CHARLES SNYDER					18. Mother's Name (First, Middle, Maiden Surname) NANCY KRAMER				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) GIOIA L. SNYDER/spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Tommy True Ct. BALTO. Md. 21234				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILLS		Data MARCH 4 1996		20c. Location - City or Town, State MIDDLE RIVER			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility EVANS Chapel of MEMORIES 8800 HARTFORD Rd BALTO. Md. 21234				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Self inflicted shotgun wound of head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) MAR 1 96		28b. Time of Injury 0600 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred self-inflicted		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME				28f. Location (Street and Number or Rural Route Number, City or Town, State) 9 TOMMY TRUE CT. BALTO				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. Crossan O'Donovan		29c. License number DO 7632		29d. Date signed (Month, Day, Year) MAR 4 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CROSSAN O'DONOVAN, MD. 2112 DUNDALK AVE. BALTO MD 21222										
31. Date filed (Month, Day, Year) MAR 6 7 1996		32. Registrar's Signature <i>[Signature]</i>								

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE MAE SHARPE				2. Date of Death Month MARCH Day 14 Year 1996		3. Time of Death 5:30PM
	4a. Facility Name (If not Institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a
Funeral Director	5. Social Security Number 219 22-2009	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 30, 1922	9. Birthplace (State or Foreign Country) S. CAROLINA
	Usual Residence of Decedent						
10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1738 YOKONA ROAD				10f. Zip Code 21234		10g. Citizen of What Country? UNITED STATES	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 th College (1-4or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAN		16b. Kind of Business/Industry SCHOOL	
17. Father's Name (First, Middle, Last) MAE SHARPE WILLIAM CHISHOLM				18. Mother's Name (First, Middle, Maiden Surname) SARAH BAILEY			
19a. Informant's Name/Relationship (Type, Print) MAE SHARPE - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1738 YOKONA ROAD, BALTIMORE, MD 21234			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHELTENHAM VA CEMETERY		Date 3-11		20c. Location - City or Town, State CHELTENHAM, MARYLAND	
21. Signature of Funeral Service Licensee Karen M. Koger				22. Name and Address of Facility WM. C. MARCH FH.-1101 E. NORTH AE.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)							
a. SEVERE PNEUMONIA							TWO WEEKS
Due to (or as a consequence of):							
b. MULTIPLE ORGAN FAILURE							TWO WEEKS
Due to (or as a consequence of):							
c.							
Due to (or as a consequence of):							
d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
ACUTE RENAL FAILURE							
DIABETES MELLITUS							
FUNGEMIA							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature] MD				29c. License number P08233		29d. Date signed (Month, Day, Year) 3/14/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GOOD SAMARITAN HOSPITAL CATHERINE APALOO MD, 5601 LOCH RAVEN BLVD BALTO MD 21239							
31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature Jahia Arvelon-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

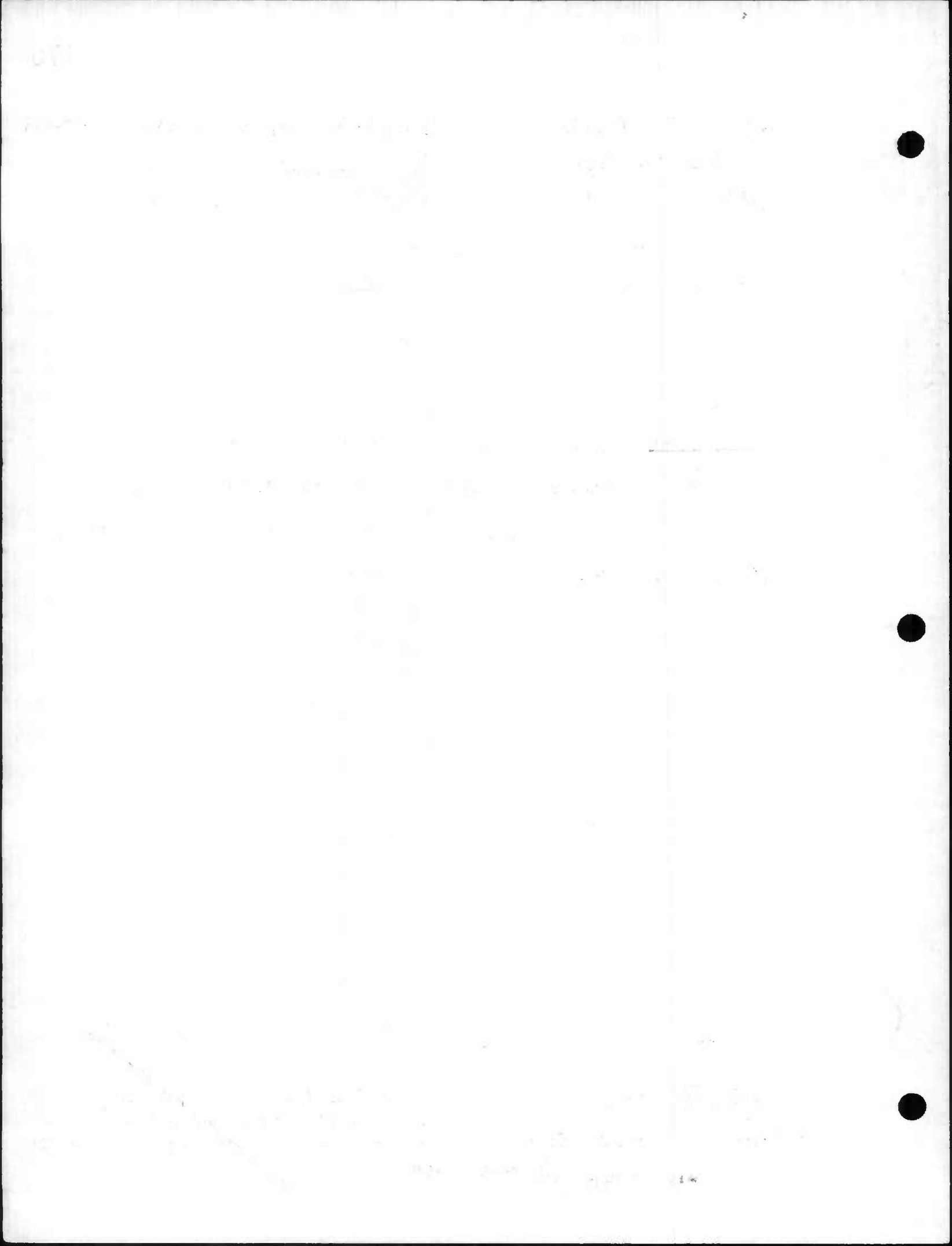
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State Registrar



1. FOR STATE REGISTRAR ^{3/1/96} **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
CERTIFICATE OF DEATH G-733 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patricia A. Smith				2. DATE OF DEATH MONTH DAY YEAR 2-27 96		3. TIME OF DEATH 10:25 AM	
4. SOCIAL SECURITY NUMBER 215-74-6426		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-16-58	
9a. FACILITY NAME (If not institution, give street and number) Alleghis Mount Clare				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Balt. City	
10a. STATE MD		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore, MD		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 810 N. Carey St.				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) High School				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper		16b. KIND OF BUSINESS/INDUSTRY NA	
17. FATHER'S NAME (First, Middle, Last) James S. Bradley, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Inez Bradley Patterson			
19a. INFORMANT'S NAME (Type/Print) Inez Bradley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 N. Carey St. Baltimore, MD 21217			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State Catonsville, MD		20d. DATE 2/29/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gabrielle Cook				22. NAME AND ADDRESS OF FACILITY March F. H. West 4300 Wilbur Avenue Baltimore, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Hestleman				29c. LICENSE NUMBER D21569		29d. DATE SIGNED (Month, Day, Year) 3/1/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Hestleman 1777 Kensington #365							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE John Hestleman			

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06677

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael John Shields Jr.				2. Date of Death Month March Day 7 Year 1996		3. Time of Death 3:50 AM													
	4a. Facility Name (If not institution, give street and number) 1200 Edmondson Avenue				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore													
Funeral Director	5. Social Security Number 046-40-8036		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 11, 1948	9. Birthplace (State or Foreign Country) Connecticut												
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Catonsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	10e. Street and Number 1200 Edmondson Avenue				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.													
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1966-1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Agent			16b. Kind of Business/Industry U.S. Government														
	17. Father's Name (First, Middle, Last) Michael J. Shields, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Noroski															
	19a. Informant's Name/Relationship (Type, Print) Arlene B. Shields (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Edmondson Avenue Catonsville, Maryland 21228															
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory March 12, 1996		20c. Location - City or Town, State Catonsville, Maryland															
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland															
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>metastatic lung cancer</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 yr 8 mos.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="2"></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	metastatic lung cancer	Approximate Interval Between Onset and Death 1 yr 8 mos.	Due to (or as a consequence of):		b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	metastatic lung cancer	Approximate Interval Between Onset and Death 1 yr 8 mos.																	
	Due to (or as a consequence of):																			
	b.	Due to (or as a consequence of):																		
	c.	Due to (or as a consequence of):																		
d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier 				29c. License number D40850		29d. Date signed (Month, Day, Year) March 7, 1996														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229																				
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06678

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANDREW L. SPRAGGINS, Sr				2. Date of Death Month March Day 3 Year 1996		3. Time of Death 6:20 PM	
	4a. Facility Name (If not institution, give street and number) Md Baptist Home For Aging				4b. City, Town, or Location of Death Baltimore		4c. County of Death WA	
Funeral Director	5. Social Security Number 224-28-2195	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Sept 28, 1914		9. Birthplace (State or Foreign Country) Va
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md	10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 300 N. Edgewood street			10f. Zip Code 21229		10g. Citizen of What Country? U.S.A		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (14 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fireman		16b. Kind of Business/Industry Gas & Electric Co			
	17. Father's Name (First, Middle, Last) Mitchell Spraggins				18. Mother's Name (First, Middle, Maiden Surname) Mary Bruce			
19a. Informant's Name/Relationship (Type, Print) Killie Spraggins wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 N. Edgewood Street Baltimore, Md 21229				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem Park		Date 3/17/96		20c. Location - City or Town, State Arbutus, Md	
21. Signature of Funeral Service Licensee Wesley Edmond				22. Name and Address of Facility March F. H. West 4300 Wabash Avenue				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) End stage chronic renal failure							4 yrs
	Due to (or as a consequence of): Hypertension							104-8
	Due to (or as a consequence of): Atherosclerotic heart disease							5 yrs
	Due to (or as a consequence of): Congestive heart failure							4 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier [Signature]			29c. License number D 36494		29d. Date signed (Month, Day, Year) 3/1/96
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James H. West 4600 Wilkins Ave Baltimore MD 21229								
31. Date filed (Month, Day, Year) MAR 07 1996			32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Stephanie Seegars</i>		2. Date of Death Month <i>March</i> Day <i>4</i> Year <i>1996</i>		3. Time of Death <i>1.30p.m.</i>	
4a. Facility Name (If not institution, give street and number) <i>809 N. Augusta</i>		4b. City, Town, or Location of Death <i>Balto</i>		4c. County of Death <i>NIA</i>	
5. Social Security Number <i>215-74-5176</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>38</i> Yrs.	
8. Data of Birth (Month, Day, Year) <i>Jan 9, 1958</i>		9. Birthplace (State or Foreign Country) <i>Ind</i>			
Usual Residence of Decedent					
10e. State <i>md</i>		10b. County <i>NIA</i>		10c. City, Town or Location <i>Balto</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>809 N. Augusta Ave</i>		10f. Zip Code <i>21229</i>		10g. Citizen of What Country? <i>U.S.A</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
15. Decedent's Education (Specify only highest grade completed) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurse</i>		16b. Kind of Business/Industry <i>Nursing Home</i>	
17. Father's Name (First, Middle, Last) <i>Stephen E. Morris</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Marion Lewis</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Marion Bush - mother</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>809 N. Augusta Ave Balto, md 21229</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Pk</i>		20c. Location - City or Town, State <i>3-9-96 Randallstown, md</i>	
21. Signature of Funeral Service Licensee <i>John March</i>		22. Name and Address of Facility <i>March F.H. West 4300 Wabash Ave Balto, md 21215</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Acquired Immunodeficiency Disease (AIDS)</i> Due to (or as a consequence of): b. <i>-</i> Due to (or as a consequence of): c. <i>-</i> Due to (or as a consequence of): d. <i>-</i>					
Approximate Interval Between Onset and Death <i>6 years</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure</i> <i>Complications of HIV - Arter.</i> <i>Seizures, Multiple Infections</i>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <i>n/a</i>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day Year) <i>-</i>		28b. Time of Injury <i>-</i> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <i>-</i>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <i>-</i>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Robert H. Gray MD</i>		29c. License number <i>D09212</i>		29d. Date signed (Month, Day, Year) <i>3/5/96</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>114 Macmillan Ave, Baltimore 101 W Reed St, Baltimore, Md.</i>					
31. Date filed (Month, Day, Year) <i>MAR 07 1996</i>					
32. Registrar's Signature <i>John A. ...</i>					

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06680

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANTWON W. SCOTT		2. Date of Death MARCH 03 1996		3. Time of Death 3:20 AM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER		4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-88-9759	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 17, 1975
	9. Birthplace (State or Foreign Country) md					
Usual Residence of Decedent						
10a. State md		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3134 Oakford Ave			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) Winston H. Scott			18. Mother's Name (First, Middle, Maiden Summa) Lavene Woolfolk			
19a. Informant's Name/Relationship (Type, Print) Lavene Woolfolk			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3134 Oakford Ave Baltimore, md 21215			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem Pl		20c. Location - City or Town, State 3/8/96 Arbutus, md		
21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility March F.H. West 4300 Wabash Ave			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immadiata Causa (Final disease or condition resulting in death) a. Gunshot wounds of thorax and abdomen Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						
23b. Did tobacco use contribute to the causa of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 3-3-96		28b. Time of Injury 0225 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28d. Describe how injury occurred Subject shot		
		28f. Location (Street and Number or Rural Route Number, City or Town, State) Glenn Michael Lane, Randallstown				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and Title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 03, 1996		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) MAR 07 1996						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06681

ITEM: 16a, PER STATE ANATOMY BOARD FILM G-733 3/7/96 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ESTHER M. SMITH				2. DATE OF DEATH MONTH DAY YEAR February 25, 1996		3. TIME OF DEATH 4:15 a.	
4. SOCIAL SECURITY NUMBER 213-01-9735		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1903	
9a. FACILITY NAME (If not institution, give street and number) Homewood Retirement Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 31 W. Patrick Street		10f. ZIP CODE 21701	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES unknown	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown				16b. KIND OF BUSINESS/INDUSTRY unknown		17. FATHER'S NAME (First, Middle, Last) Thomas Murray	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Francis Hering				19a. INFORMANT'S NAME (Type/Print) (son) Richard Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) State rem.				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) State rem.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Dir.				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Anterior subarachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF): ~10 yrs b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Hypertrophic cardiomyopathy, Chronic obstructive pulmonary disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Francis E. Becker MD				29c. LICENSE NUMBER D30496 MD		29d. DATE SIGNED (Month, Day, Year) 2/25/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis E. Becker MD; 300 W 9th St; Frederick MD 21701							
31. DATE FILED (Month, Day, Year) MAR 07 1996				32. REGISTRAR'S SIGNATURE Judi Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

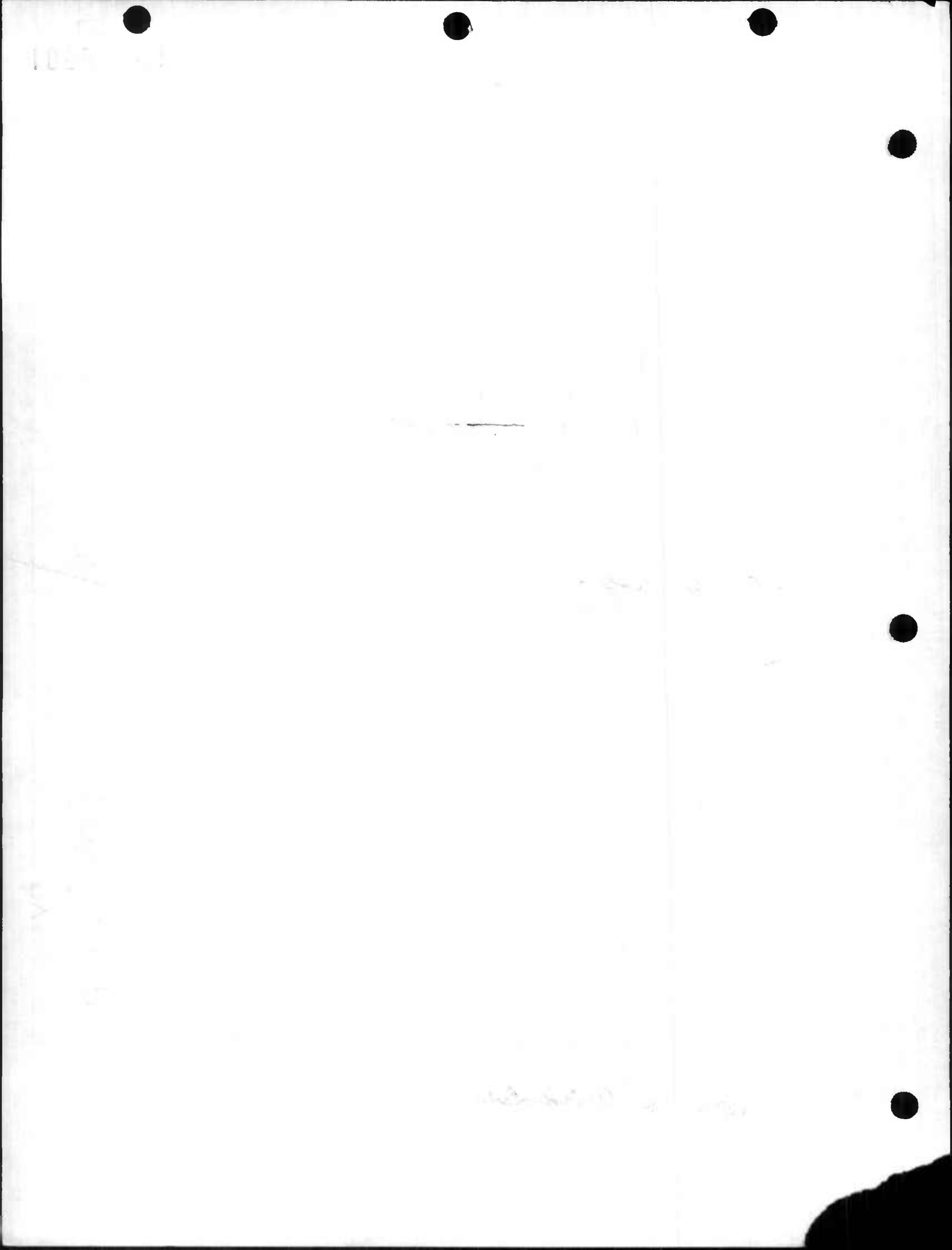
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elliott William Singleton					2. Date of Death Month February Day 28 Year 1996		3. Time of Death 7:09 pm.	
	4a. Facility Name (If not institution, give street and number) Univ. of Md. Med. Ctr.					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number n/a	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 54 February 28, 1946	9. Birthplace (State or Foreign Country) Md.		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md.	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No			
	10e. Street and Number 1203 Southview Rd.			10f. Zip Code 21218		10g. Citizen of What Country? USA			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) infant		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) infant		16b. Kind of Business/Industry n/a				
	17. Father's Name (First, Middle, Last) Craig Singleton				18. Mother's Name (First, Middle, Maiden Surname) Debra Singleton JOHNSON				
	19a. Informant's Name/Relationship (Type, Print) Debra Singleton			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1203 Southview Rd. Baltimore, Md. 21218					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley		20c. Date 3/5/96		20d. Location - City or Town, State Towson, Md.		
	21. Signature of Funeral Service Licensee James A. Morton			22. Name and Address of Facility James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Cystadenoma toid Malformation of Left Lung								
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cystadenoma toid Malformation of Left Lung Due to (or as a consequence of):								
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prematurity, Pneumothoraces, Shock, Possible R pulmonary hypoplasia								
	24a. Was an autopsy performed? 1 Yes 2 No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)						
	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Lillian R. Blackmon M.D.		29c. License number MD 26066		29d. Date signed (Month, Day, Year) February 28, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lillian R. Blackmon, University of Maryland Hospital									
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature John Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06683

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN PHILIP VINCENT, SR.						2. Date of Death Month Day Year MARCH 3, 1996		3. Time of Death 6:37 AM	
	4a. Facility Name (If not institution, give street and number) 329 WHITFIELD ROAD						4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-22-3520		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 12, 1927		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 329 WHITFIELD ROAD				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TESTER			16b. Kind of Business/Industry C & P TELEPHONE			
17. Father's Name (First, Middle, Last) WILBUR VINCENT						18. Mother's Name (First, Middle, Maiden Summa) GLADYS MURK				
19a. Informant's Name/Relationship (Type, Print) CAROL VINCENT / WIFE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 WHITFIELD ROAD, CATONSVILLE, MARYLAND 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		Date MARCH 6, 1996		20c. Location - City or Town, State ELKRIDGE, MARYLAND				
21. Signature of Funeral Service Licensee <i>Neil E. Kim</i> MO0877				22. Name and Address of Facility LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>metastatic colon cancer</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate interval Between Onset and Death <i>1 year</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Yvonne Ottaviano</i> MD		29c. License number D40850		29d. Date signed (Month, Day, Year) MARCH 4, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YVONNE OTTAVIANO, M.D. ST. AGNES HOSPITAL, 900 CATON AVE., BALTIMORE, MD 21229										
31. Date filed (Month, Day, Year) MAR 07 1996		32. Registrar's Signature <i>Jebia D. [Signature]</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

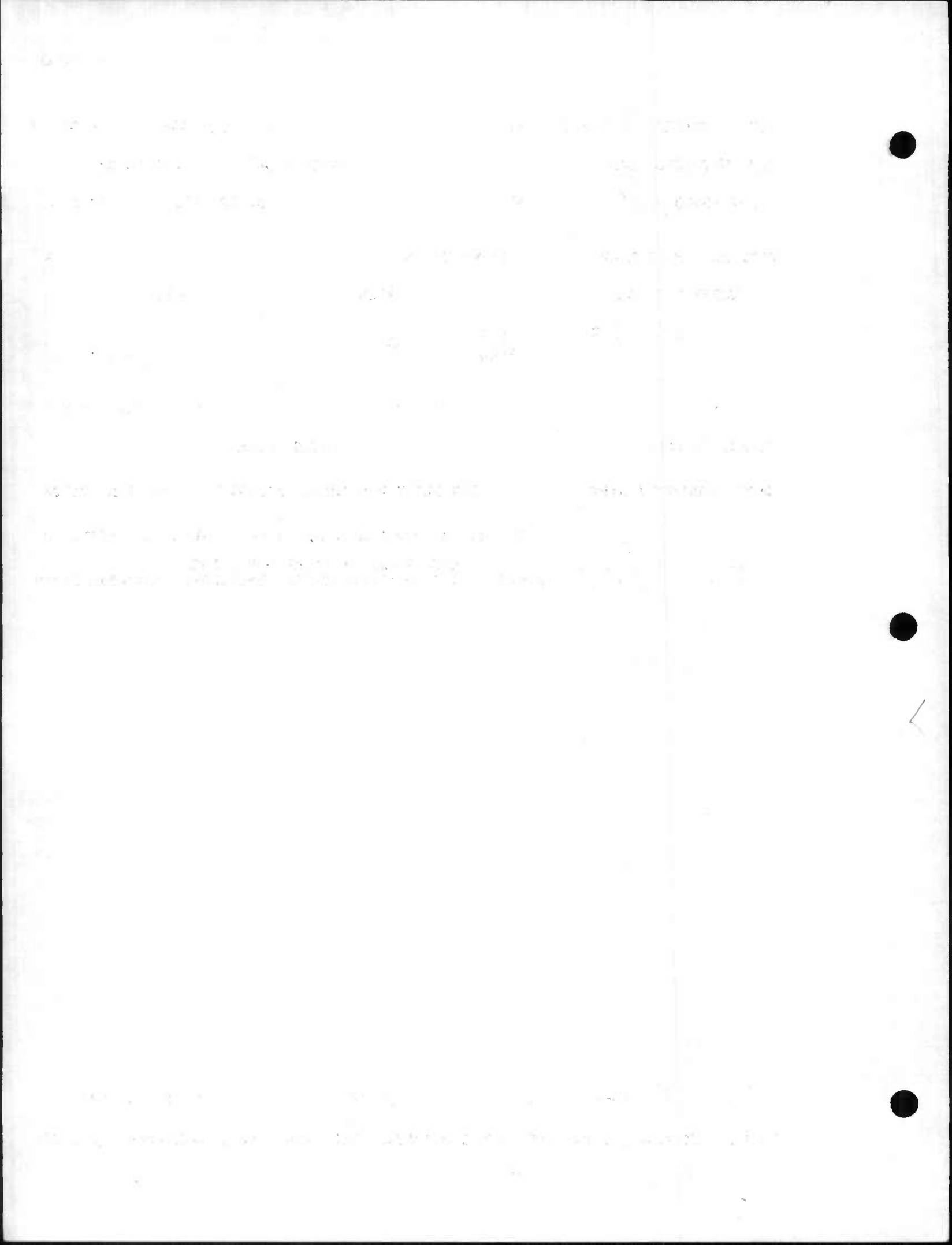
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06684

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Rose Caroline Veronneau</i>				2. Date of Death Month <i>February</i> Day <i>27</i> Year <i>1996</i>		3. Time of Death <i>10⁵⁰ PM</i>	
	4a. Facility Name (If not Institution, give street and number) <i>HARFORD MEMORIAL HOSPITAL</i>				4b. City, Town, or Location of Death <i>HARFORD</i>		4c. County of Death <i>HARFORD</i>	
Funeral Director	5. Social Security Number <i>013-50-1613</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>88</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <i>JUNE 9, 1907</i>	9. Birthplace (State or Foreign Country) <i>CANADA</i>
	Usual Residence of Decedent							
10a. State <i>MARYLAND</i>		10b. County <i>HARFORD</i>		10c. City, Town or Location <i>STREET</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>3553 GRISER NURSERY ROAD</i>				10f. Zip Code <i>21154</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>		
15. Decedent's Education (Specify only highest grade completed) <i>12 YRS.</i>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>AT HOME</i>		18b. Kind of Business/Industry <i>Housewife</i>		
Elementary/Secondary (0-12)				College (1-4or 5+)				
17. Father's Name (First, Middle, Last) <i>LAURENT GAUDETTE</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ALBERTINE MORINVILLE</i>				
19e. Informant's Name/Relationship (Type, Print) <i>EVA L. RSYNOLOS</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>101 RAINBOW DRIVE LIVINGSTON, TEXAS 77351</i>				
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GREEN MOUNT CEMETERY</i>		Date <i>MARCH 4, 1996</i>		20c. Location - City or Town, State <i>BALTIMORE MARYLAND</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>EVANS FUNERAL CHAPEL - BEL AIR, P.A. 31050 3 NEWPORT DRIVE FOREST HILL, MARYLAND</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis</i> Due to (or as a consequence of): <i>Atrial Fibrillation</i> Due to (or as a consequence of): <i>Aspiration Pneumonia</i> Due to (or as a consequence of): <i>'G' Tube placement</i>								Approximate Interval Between Onset and Death <i>Days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimers Disease</i> <i>Multiple Contracture</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i> MIRZA A. BAIG		29c. License number <i>D43115</i>		29d. Date signed (Month, Day, Year) <i>2.28.96</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>DR. MIRZA A. BAIG HARFORD MEMORIAL HOSPITAL</i>								
31. Date filed (Month, Day, Year) <i>MAR 07 1996</i>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

4

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

96 06685

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CALVIN WALLER				2. Date of Death Month March Day 1 Year 1996				3. Time of Death 10:50 AM			
	4a. Facility Name (If not Institution, give street and number) 2731 Mura Street				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A			
Funeral Director	5. Social Security Number 245-54-5564		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth Month Nov Day 19 Year 1934		9. Birthplace (State or Foreign Country) GRANVILLE CO.			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2731 Mura Street				10f. Zip Code 21213		10g. Citizen of What Country? United States					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Grocery Stand				
	17. Father's Name (First, Middle, Last) Ollie Waller				18. Mother's Name (First, Middle, Maiden Surname) Maria Clements							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Crystal Walters				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2731 Mura Street, Baltimore, MD 21213							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		Date 3-6-96		20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility March Funeral Home 1101 E. North Avenue, Baltimore, MD 21202							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic lung cancer - squamous cell Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. { Due to (or as a consequence of): c. { Due to (or as a consequence of): d. {										Approximate Interval Between Onset and Death 8 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dehydration							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 		29c. License number 49541		29d. Date signed (Month, Day, Year) 3/6/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Chang, M.D. The Johns Hopkins Hospital, Tower 110, Doctors Lounge, Baltimore MD 21287												
31. Date filed (Month, Day, Year) MAR 6 7 1996 32. Registrar's signature 												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 06686

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret E. Woolford</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Mar. 6, 1996</i>		3. TIME OF DEATH <i>1:50 a.m.</i>	
4. SOCIAL SECURITY NUMBER <i>214-14-8728</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>MAY 6, 1921</i>	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2205 SMITH AVENUE				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) ALBERT V. CHAILLOU				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET B. YOUNG			
19a. INFORMANT'S NAME (Type/Print) ELMER C. WOOLFORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 SMITH AVENUE, BALTIMORE, MARYLAND 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE MAR. 9, 1996		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thelma E. Rine</i>		22. NAME AND ADDRESS OF FACILITY LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, MD 21229		22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute myocardial infarction</i> 6 hours					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Atherosclerotic cardiovascular disease</i> 4 years					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Institutional mega colon, hypothyroidism, previous cerebro-vascular acc.</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Yelena Lipnik M.D.</i>				29c. LICENSE NUMBER P07532		29d. DATE SIGNED (Month, Day, Year) Mar. 6, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Yelena Lipnik, 900 Caton Ave, Baltimore MD 21229</i>							
31. DATE FILED (Month, Day, Year) MAR 07 1996 <i>Johanna B. Rine</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06687

ITEMS: 10e, & 15, PER STATE ANATOMY BOARD FILM G-733 3/7/96 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elmer Watkins		2. DATE OF DEATH MONTH DAY YEAR February 17 1996		3. TIME OF DEATH 11:00 A.M.	
4. SOCIAL SECURITY NUMBER 212-30-2642		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.	
7. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1933		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Bon Secour Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 1807 1890 W. Pratt Street			10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (13-16) unknown Graduate (17-24) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) Elmer Leo Watkins, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Gwendolyn L. Bond		
19a. INFORMANT'S NAME (Type/Print) (sister) Mary E. Veaux			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9840 Magledt Road-Baltimore, Maryland 21234		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) State rem.		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSER Ronald S. Wade, Dir.			22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory failure		Approximate Interval Between Onset and Death 15 mins	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Pneumonia		10 days	
		c. _____			
		d. _____			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcohol abuse					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Ockaney		29c. LICENSE NUMBER D-40521		29d. DATE SIGNED (Month, Day, Year) February 17, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR OCKANEY 3350 Wilkes Avenue Suite 306 Baltimore MD 21229.					
31. DATE FILED (Month, Day, Year) MAR 07 1996		32. REGISTRAR'S SIGNATURE J. B. Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

78330 05

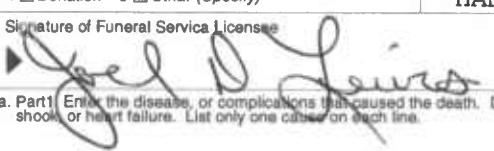
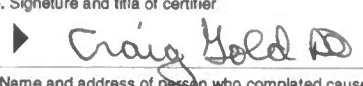
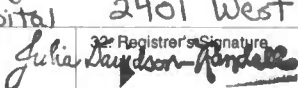
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06688

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Weissman				2. Date of Death Month March Day 4 Year 1996		3. Time of Death 0903 AM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-03-4759		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 3, 1909	9. Birthplace (State or Foreign Country) MASS
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3601 FORDS LANE; APT. 806				10f. Zip Code 21215		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR/OWNER			16b. Kind of Business/Industry CLEANING SERVICE	
17. Father's Name (First, Middle, Last) MORRIS WEISSMAN				18. Mother's Name (First, Middle, Maiden Surname) FANNIE PREPIOR				
19a. Informant's Name/Relationship (Type, Print) MRS. ELEANOR WEISSMAN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 FORDS LA; APT. 806; BALTO, MD 21215				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI		Date 3-6-1996		20c. Location - City or Town, State OWINGS MILLS, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Enterocolitis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Chronic Obstructive Pulmonary Disease Cerebral Vascular Accident						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number A5 2402321-CG-9919		29d. Date signed (Month, Day, Year) March 4, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig Gold MD Sinai Hospital 2401 West Belvedere Avenue Baltimore, Maryland 21215								
31. Date filed (Month, Day, Year) MAR 07 1996			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

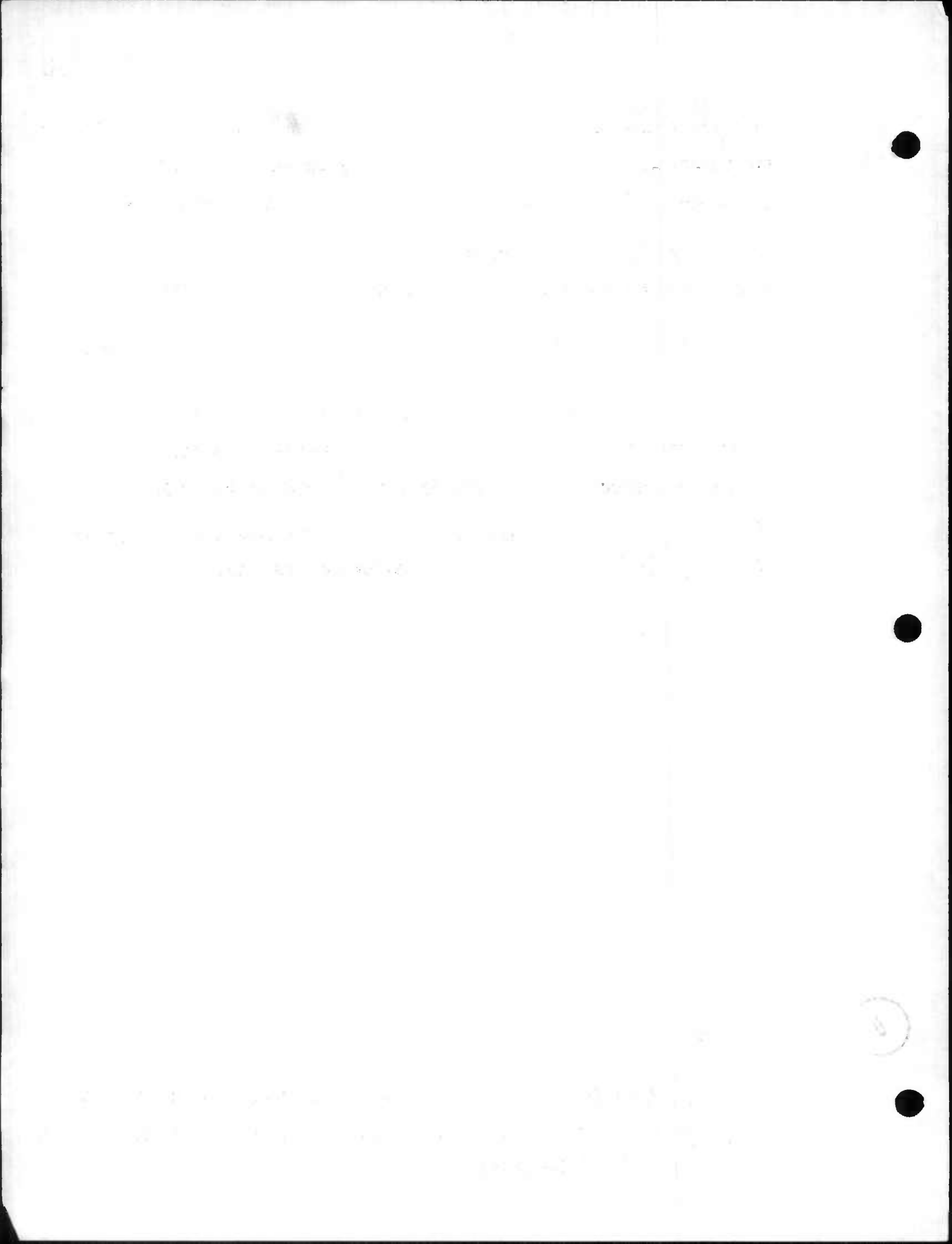
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06689

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MOSES WASHINGTON				2. Date of Death Month Day Year MARCH 3 1996		3. Time of Death 9 30 pm	
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE TOWSON				4b. City, Town, or Location of Death N/A		4c. County of Death BALTO	
Funeral Director	5. Social Security Number 247-66-4353		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 25 1941	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) S.C.					
To Be Completed by Funeral Director	10a. State MD		10b. County BALTO		10c. City, Town or Location RANDALLSTOWN		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3848 TWIN LAKES CT.				10f. Zip Code 21244		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) 2YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASST. MGR HOUSEKEEPING		16b. Kind of Business/Industry UNIVERSITY			
	17. Father's Name (First, Middle, Last) BRACIE WASHINGTON				18. Mother's Name (First, Middle, Maiden Sumame) BELVIN RICHEY			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JANICE M. WASHINGTON-WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3848 TWIN LAKES CT. BALTO, MD 21244			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTVIEW CEMETERY		20c. Location - City or Town, State 3-9-96 ANDERSON S.C.			
	21. Signature of Funeral Service Licensee <i>James H. Thompson</i>				22. Name and Address of Facility MARCH F/H-WEST 4300 WABASH AVE			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BRAIN METASTASES Due to (or as a consequence of): b. LUNG CANCER, non-small cell Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 months 1 year.			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bone metastases				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Kendall R Faulkner</i>				29c. License number D25643		29d. Date signed (Month, Day, Year) 3/4/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Kendall R Faulkner</i> 2300 Dulaney Valley Rd Towson md 21204							
State Registrar	31. Date filed (Month, Day, Year) MAR 07 1996				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Belle June H. Burnham</u>				2. DATE OF DEATH MONTH <u>FEBRUARY</u> DAY <u>28</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>11:45 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>217-18-8102</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>77</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>June 11, 1918</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Ohio</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Union Memorial Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>	
9c. COUNTY OF DEATH <u>n/a</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>	
10c. CITY, TOWN OR LOCATION <u>McDonough</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>600 Sudbrook Road</u>	
10f. ZIP CODE <u>21208</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12th grade</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Sales</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Retail</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Melvin Harris</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Marian "unknown"</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Rick Burns (guardian)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>unknown</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>State Anatomy Board-655 W. Baltimore Street</u> <u>Room B026-Baltimore, Maryland 21201-1559</u>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Ronald S. Wade, Dir.</u> <u>3/7/96</u>				22. NAME AND ADDRESS OF FACILITY <u>State Anatomy Board-655 W. Baltimore Street</u> <u>Room B026-Baltimore, Maryland 21201-1559</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis Syndrome</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <u>Acute Renal Failure</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>Gastrointestinal bleeding</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CVA</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Robert McKinney D.O.</u>				29c. LICENSE NUMBER <u>AT2438946515</u>		29d. DATE SIGNED (Month, Day, Year) <u>02/28/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Robert McKinney, DO, Union Memorial Hospital 201 E. Univ. Pkwy Balt. MD 21218</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 0 8 1996</u>				32. REGISTRAR'S SIGNATURE <u>Judi Shuster-Kovach</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06691

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARK ANTHONY BECKWITH				2. DATE OF DEATH MONTH MARCH DAY 6 YEAR 96		3. TIME OF DEATH 4:45 a m	
4. SOCIAL SECURITY NUMBER 218-90-7407		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04 21 62	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL-HOSPICE		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MD.			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 300 KANE STREET			
10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) HOUSEWORK				16. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN BECKWITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) JACQUELINE ROE			
19a. INFORMANT'S NAME (Type/Print) RUTH BECKWITH, WIFE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 KANE ST. BALTO. MD. 21224			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DARLAWN CEMETERY 3896 EASTWOOD, MD.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles B. Zuber				22. NAME AND ADDRESS OF FACILITY CHARLES S. ZIEGLER + SON INC. 6224 EASTERN AVE. BALTO. MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer Approximate Interval Between Onset and Death ~9 mos. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Zuber				29c. LICENSE NUMBER D40480		29d. DATE SIGNED (Month, Day, Year) March 7, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO, MD. 5810 BELAIR RD. BALTO., MD 21206							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE J. H. H. H. H.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA BOTMAN				2. DATE OF DEATH MONTH 2 DAY 28 YEAR 96		3. TIME OF DEATH 10:28 PM	
4. SOCIAL SECURITY NUMBER 021-10-8839		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 15, 1910	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GR. WASHINGTON		10. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE, MD	
11. RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY MONTGOMERY				10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6121 Montrose Road				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) William Galer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Unavailable			
19a. INFORMANT'S NAME (Type/Print) Steven L. Botman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4921 Crescent Street, Bethesda, Maryland 20816			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Mem. Gdns 3/1/96		20c. LOCATION — City or Town, State Falls Church Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Lives-Pearson Funeral Homes Falls Church, Virginia 22046			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Colon DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 6 mos.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) FEB 29, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shomacher MD 2309 Shorefield Rd Wheaton, MD 20902							
31. DATE FILED (Month, Day, Year) MAR 08 1996		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06694

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Luther Black				2. DATE OF DEATH MONTH MAR DAY 7 YEAR 1996		3. TIME OF DEATH 6:40 A.M.	
4. SOCIAL SECURITY NUMBER 220-24-4350		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC 18.1929	
9a. FACILITY NAME (If not institution, give street and number) 633 East Aisquith St., Apt. 14L				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 633 East Aisquith St., Apt. 14L				10f. ZIP CODE 21202		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor		16b. KIND OF BUSINESS/INDUSTRY Cleaning Service	
17. FATHER'S NAME (First, Middle, Last) James Black				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys "Unknown"			
19a. INFORMANT'S NAME (Type/Print) Robin Inez Owens				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Shannon Forest Ct. Glen Burnie, MD 21060			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/08/96		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF): Metastasis Lung							
c. DUE TO (OR AS A CONSEQUENCE OF): Renal Cell Carcinoma							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert C. Irwin MD				29c. LICENSE NUMBER 008900		29d. DATE SIGNED (Month, Day, Year) 3-7-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert C. Irwin MD 828 N. Eutaw St. Balto Md 21201							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE Juli Anderson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06695

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CORA CATHERINE BOWLING

2. Date of Death

Month Day Year
MARCH 04 1996

3. Time of Death

10:12 PM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

225-30-9126

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 1, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Pylesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1935 Telegraph Road

10f. Zip Code

21132

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Food Processing

17. Father's Name (First, Middle, Last)

Thomas Matney

18. Mother's Name (First, Middle, Maiden Surname)

Sally Vance

19a. Informant's Name/Relationship (Type, Print)

Shellia Ann Bowles

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

445 Bair Road, Delta, Pa. 17314

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Darlington Cemetery

Date

3/7/96

20c. Location - City or Town, State

Darlington, Md.

21. Signature of Funeral Service Licensee

J.J. Hartenstein

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.

19 S. Main St., Stewartstown, Pa. 17363-0325

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL HEMORRAGE

Approximate Interval Between Onset and Death

3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA

PERIPHERAL VASCULAR DISEASE

ESSENTIAL THROMBOCYTHEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joan P. Edwards, M.D.

29c. License number

D 31775

29d. Date signed (Month, Day, Year)

MARCH 4, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOAN P. EDWARDS, M.D.
2112 BELAIR ROAD FALLSTON, MARYLAND 21047

31. Date filed (Month, Day, Year)

MAR 08 1996

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06696

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KEITH BAILEY						2. Date of Death Month Day Year March 1, 1996		3. Time of Death 7:45 am		
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER						4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 216-84-4423		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 29 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 17 66		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1828 St. Paul Apt. 101				10f. Zip Code 21202		10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker			16b. Kind of Business/Industry Morgan State Univ.				
17. Father's Name (First, Middle, Last) VICTOR PAGE JOHNSON						18. Mother's Name (First, Middle, Maiden Summa) SHARON D. BAILEY					
19a. Informant's Name/Relationship (Type, Print) SHARON BAILEY/ Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1828 St. Paul St. Apt. 101 21202 Md.							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Zion			20c. Location - City or Town, State 3/6/96 Lansdowne, Maryland					
21. Signature of Funeral Service Licensee <i>Joseph R. Watter</i>				22. Name and Address of Facility UNITY FUNERAL HOME 108 W. NORTH AVENUE BALTO. MD. 21201							
23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non-Hodgkins Lymphoma Due to (or as a consequence of): b. Adult immunodeficiency Syndrome Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 year year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>W.A. Riley, MD</i>				29c. License number D25205			
				29d. Date signed (Month, Day, Year) 3/2/96							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, MD GBMC 6701 N. Charles St. Balto. md 2120x											
31. Date filed (Month, Day, Year) MAR 0 8 1996				32. Registrar's Signature <i>John D. ...</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

96-1221-510

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-733 3/15/96 t.t


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Filing, 733, item #8, 3/8/96, cfw State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06697

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CALVIN DEXTER BOOKER				2. Date of Death Month MARCH Day 5 Year 1996		3. Time of Death 9:28 P.M.		
	4a. Facility Name (If not institution, give street and number) 4409 OLD YORK ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/a		
Funeral Director	5. Social Security Number 213-76-9746		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) 5-3-59		
	9. Birthplace (State or Foreign Country) Maryland								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4414 Old York Rd.				10f. Zip Code 21212		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Foodservice				
	17. Father's Name (First, Middle, Last) Cornelius Booker				18. Mother's Name (First, Middle, Maiden Surname) Patricia Paschall				
	19a. Informant's Name/Relationship (Type, Print) Patricia Booker (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4414 Old York Rd. Balto., Md. 21212				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 3-9		20c. Location - City or Town, State Landsdowne, Md.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Cable Funeral Service 5502 Winner Ave. Balto., Md. 21215				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3-5-96		28b. Time of Injury UNKNOWN M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred UNKNOWN		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4409 OLD YORK RD. BALTIMORE, MD.					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 6, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. Locke MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAR 08 1996		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06698

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen B. Childs

2. Date of Death
Month Day Year

3 1 1996

3. Time of Death
0315

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218180350

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB 15/1917

9. Birthplace (State or Foreign Country)

UKRANIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1819 W. Lombard Street

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bakery Worker

16b. Kind of Business/Industry

Bakery

17. Father's Name (First, Middle, Last)

Robert Hamlett

18. Mother's Name (First, Middle, Maiden Surname)

Delila

19a. Informant's Name/Relationship (Type, Print)

Helen Watson, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1819 W. Lombard St Baltimore, MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt Zion Cemetery

Date

3/6/96

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Gray Harris

22. Name and Address of Facility

5240 Reisterstown Rd
CHARMON-HARRIS F.L. Baltimore, MD 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Sepsis

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. peritonitis

Due to (or as a consequence of):

c. perforated bowel

Due to (or as a consequence of):

d. metastatic cancer

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Samuel G. Maller M.D.

29c. License number

PO 8660

29d. Date signed (Month, Day, Year)

March 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL G. MALLER

2101 Brink Court Gaithersburg MD 20878

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

John A. Radcliff

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06699

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Steaven Prince Coates				2. DATE OF DEATH MONTH DAY YEAR February 24, 1996		3. TIME OF DEATH 6:24 P M	
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. 1 24		7. DATE OF BIRTH (Month, Day, Year) DEC. 30, 1995	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 817 W. SPADOGA Street				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, White, etc. Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Infant		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) STEAVEN Coates, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tiffany LEDBETTER			
19a. INFORMANT'S NAME (Type/Print) Tiffany LEDBETTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 W. SPADOGA Street Baltimore MD 21201			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN Cemetery 2/24/96		20c. LOCATION — City or Town, State WOODLAWN Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gaylene				22. NAME AND ADDRESS OF FACILITY 5240 REISTERSTOWN RD CHARTMAN HOSPITAL N. Baltimore Md 21215			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRONCHOPULMONARY DYSPLASIA							
DUE TO (OR AS A CONSEQUENCE OF):							
b. SEPSIS							
DUE TO (OR AS A CONSEQUENCE OF):							
c. PREMATUREITY							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC DYSFUNCTION.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A.			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A.					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gaylene Verma, M.D.				29c. LICENSE NUMBER D37615		29d. DATE SIGNED (Month, Day, Year) 02-24-1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AGAY K. VERMA, M.D. UNION MEMORIAL HOSPITAL, BALTIMORE, MARYLAND							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996		32. REGISTRAR'S SIGNATURE Tina Hudson-Rodell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Filing, 733, item #17, 3/8/96, cyw, per fh

96 06700

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret L. Camino</i>				2. DATE OF DEATH MONTH DAY YEAR <i>MARCH 1 1996</i>		3. TIME OF DEATH <i>1027 A M</i>	
4. SOCIAL SECURITY NUMBER <i>141-16-9644</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>70</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 10, 1925</i>	
8. FACILITY NAME (If not institution, give street and number) <i>801 Winters Lane, Apt. 446</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i>		10. COUNTY OF DEATH <i>BALTIMORE</i>	
11. RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Catonsville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>801 Winters Lane, Apt. 446</i>				10f. ZIP CODE <i>21228</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12th grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teller</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Bank</i>			
17. FATHER'S NAME (First, Middle, Last) <i>KINCKINER</i> <i>Clarence P. Kinckiner</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ethel May (Surname Unknown)</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mary Lee Langton (dghtr)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3 Ambolin Court, Baltimore, MD 21236</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Crematory</i>		20c. DATE <i>3/5</i>		20d. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. CHRONIC OBSTRUCTIVE AIRWAY DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <i>YEARS</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Senior Residence</i>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <i>211171</i>		29d. DATE SIGNED (Month, Day, Year) <i>MARCH-1-1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>E. P. Williamson 405 Frederick Ave</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 08 1996</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i> <i>CATONSVILLE MD 21228</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Filmg, 733, item #1, 3/8/96,cyw, per fh

Certificate of Death

Reg. No.

96 06701

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bestude M. Colbers

2. Date of Death

Month March Day 3, 1996 Year

3. Time of Death

9:55 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Woods Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

172-18-1608

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Sept. 22, 1900

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State Maryland

10b. County Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 Center Place, Apt. #418

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Thomas

18. Mother's Name (First, Middle, Maiden Sumama)

(Names Unknown)

19a. Informant's Name/Relationship (Type, Print)

Eugene R. Colberg (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9337 Beowulf Circle, Baltimore, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cem.

Date

3/6/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. [Signature]

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Approximate Interval Between Onset and Death

days

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease
with recent bilateral
above knee amputation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D33943

29d. Date signed (Month, Day, Year)

3-3-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin Square Hospital Center Balto., 21237

31. Date filed (Month, Day, Year)

MAR 08 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

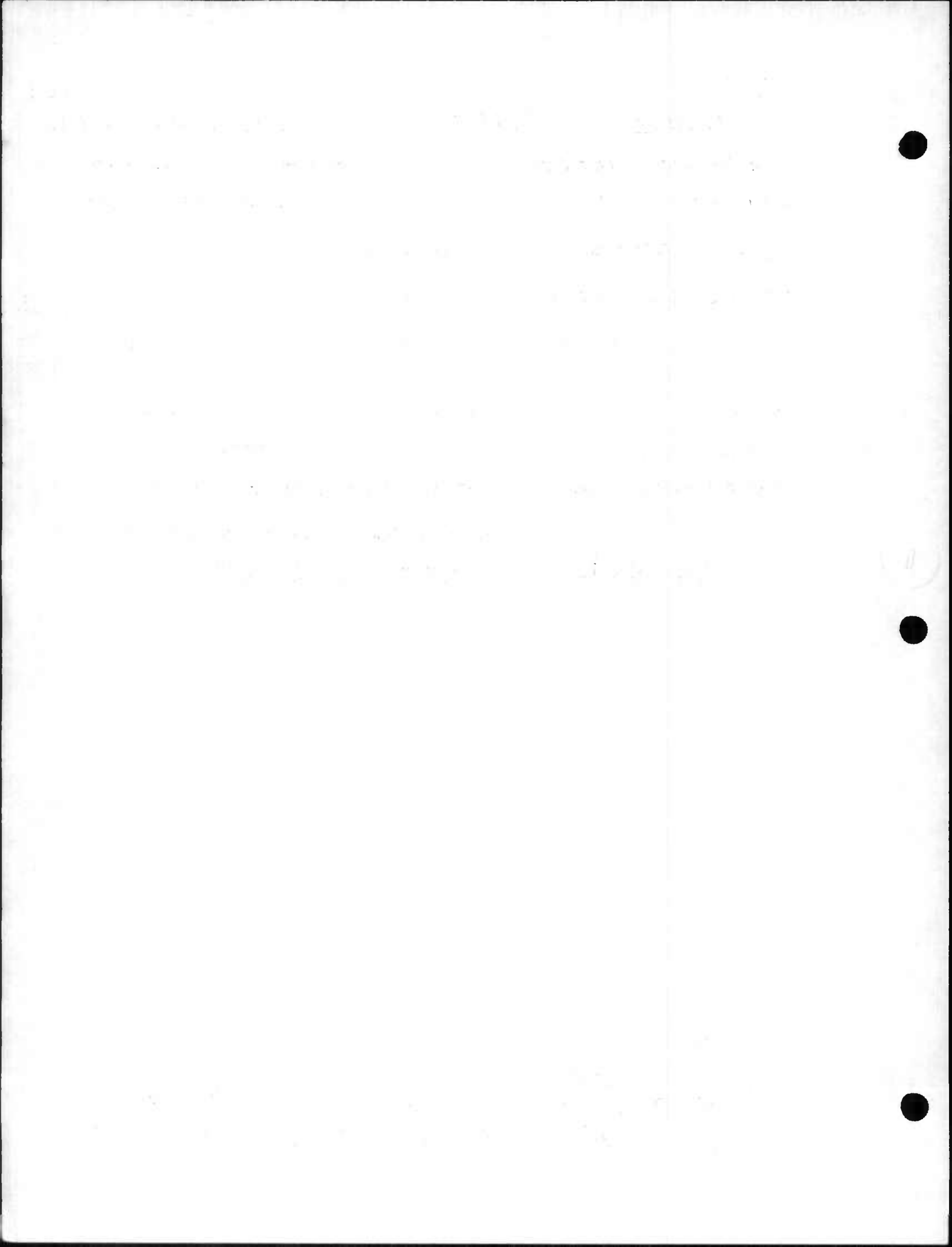
Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner


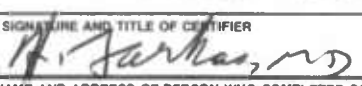
To Be Completed by Funeral Director



96 06702

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY JEANNETTE CHRISTOPHER				2. DATE OF DEATH MONTH DAY YEAR March 3, 1996		3. TIME OF DEATH 11 40 PM	
4. SOCIAL SECURITY NUMBER 219-05-4722		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 8, 1919	
9a. FACILITY NAME (If not institution, give street and number) 43 Port Herman Drive				9b. CITY, TOWN OR LOCATION OF DEATH Chesapeake City		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Chesapeake City		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 43 Port Herman Drive				10f. ZIP CODE 21915		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Advertising Executive		16b. KIND OF BUSINESS/INDUSTRY Silversmith Co.			
17. FATHER'S NAME (First, Middle, Last) John Walter Gatton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amy Hill			
19a. INFORMANT'S NAME (Type/Print) Arlene Patterson (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Port Herman Drive, Chesapeake City, Md. 21915			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 3/6/96		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 6 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD, peripheral vascular disease, colitis Wolff-Parkinson-White syndrome DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Henry Farkas, M.D., Northern Chesapeake Hospice, 239 S. Bridge St. Elkton, MD 21921					
29c. LICENSE NUMBER D15314		29d. DATE SIGNED (Month, Day, Year) 3/4/96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Henry Farkas, M.D., Northern Chesapeake Hospice, 239 S. Bridge St. Elkton, MD 21921		31. DATE FILED (Month, Day, Year) MAR 0 8 1996					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


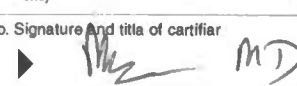
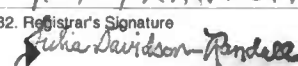
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 Filmg, 733, item #1,17,19a, 3/8/96, cyw, per fh
 Certificate of Death

96 06703

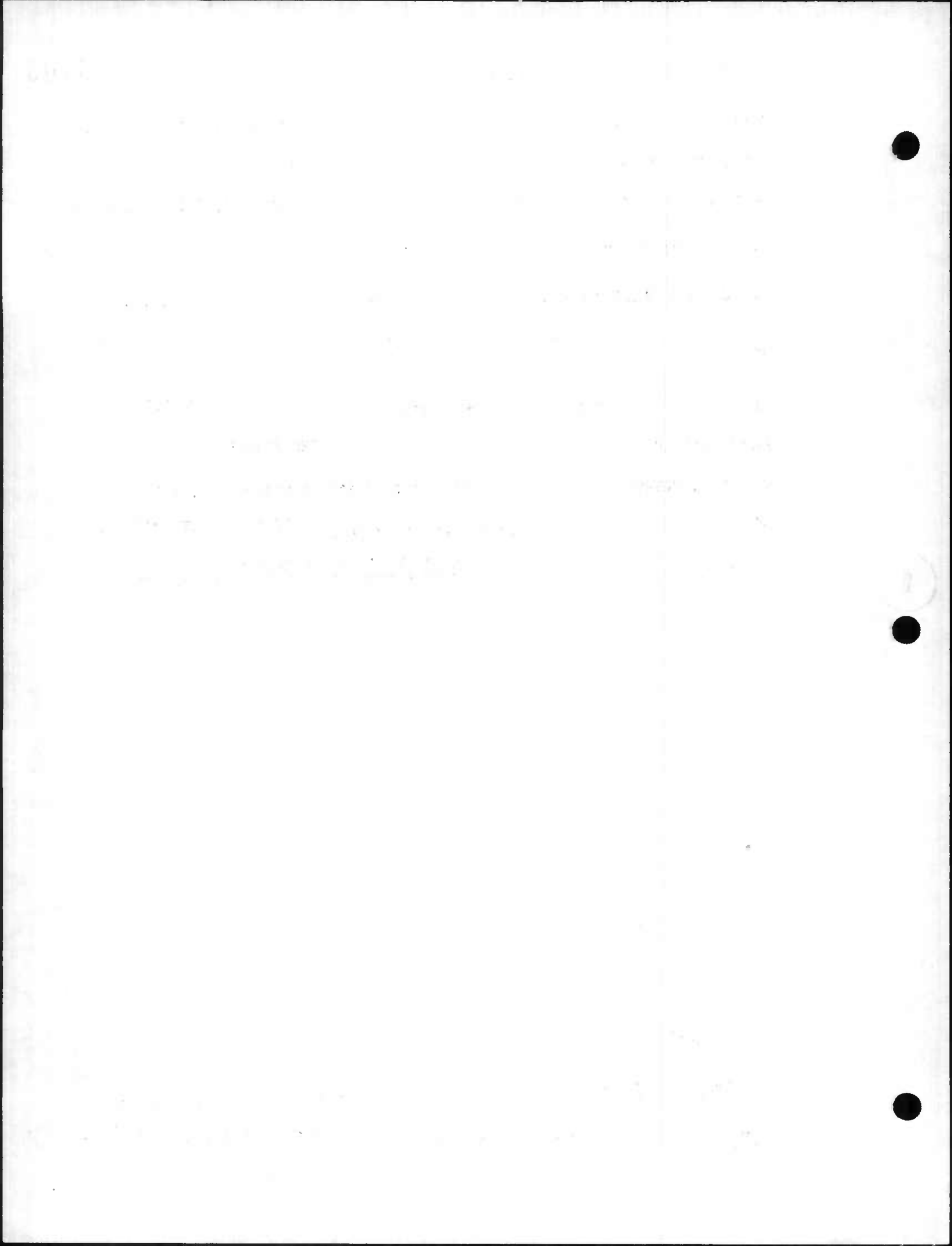
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK C. CILENTO					2. Date of Death Month MARCH 07 , Day 1996 , Year 1996		3. Time of Death 5.30 AM	
	4a. Facility Name (If not institution, give street and number) 9105 ORBITAN ROAD					4b. City, Town, or Location of Death N/A		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-01-4176		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC 27, 1912		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE		10c. City, Town or Location N/A			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 624 DALE AVE BALTIMORE MD.				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEATCUTTER			16b. Kind of Business/Industry MARKET		
	17. Father's Name (First, Middle, Last) JOSEPH CILENTO				18. Mother's Name (First, Middle, Maiden Surname) ADALINE STRAUB				
	19a. Informant's Name/Relationship (Type, Print) RAPHAEL F. CILENTO				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9105 ORBITAN ROAD BALTIMORE MD. 21234				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM.		Data 3/11	20c. Location - City or Town, State BALTIMORE MD.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HARTLEY MILLER FUNERAL HOME 7527 HARFORD ROAD BALTIMORE MD. 21234				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostate Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23f. Approximate Interval Between Onset and Death 3yrs								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier  MD				29c. License number D18487		29d. Date signed (Month, Day, Year) 3/7/96		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 9101 FRANKLIN SQ. DR, BALTO, MD 21237								
	31. Date filed (Month, Day, Year) MAR 08 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

15



96 06704

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>JOHN F. DICKARD</i>				2. DATE OF DEATH MONTH <i>MARCH</i> DAY <i>4</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>12:12 PM</i>	
4. SOCIAL SECURITY NUMBER <i>217-05-7726</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>August 22, 1919</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Keswick Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Perry Hall</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>29 Bangert Avenue</i>				10f. ZIP CODE <i>21128</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Estimator</i>		16. KIND OF BUSINESS/INDUSTRY <i>Construction Company</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Francis Andrew Dickard</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lillian Catherine Hammelann</i>			
19a. INFORMANT'S NAME (Type/Print) <i>F. Kenyon Dickard (son)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>29 Bangert Avenue, Perry Hall, MD 21128</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley Mem'l Gardens 3/1/96 Timonium, MD</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Matthew O. Roberts</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimineck Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Alzheimer's disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Isabelle MacGregor MD</i>		29c. LICENSE NUMBER <i>D13657</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 4, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. ISABELLE MACGREGOR MD, 700 W 40th STREET, BALTIMORE, MD 21211</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 0 8 1996</i>		32. REGISTRAR'S SIGNATURE <i>John A. Hatcher-Kentall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 06705

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELAINE COLLISON ELLIOTT				2. DATE OF DEATH MONTH March , DAY 5 , YEAR 1996		3. TIME OF DEATH 12:55 M	
4. SOCIAL SECURITY NUMBER 236-03-0689		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1917	
8a. FACILITY NAME (If not Institution, give street and number) Madonna Heritage Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Madonna		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 605 Wheel Road				10f. ZIP CODE 21015		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Head Cashier		16b. KIND OF BUSINESS/INDUSTRY Financial Services	
17. FATHER'S NAME (First, Middle, Last) William Melville Collison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Lowe			
19a. INFORMANT'S NAME (Type/Print) James E. Elliott (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Wheel Road, Bel Air, Md. 21015			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Parkwood Cemetery		DATE 3/8/96		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John D. Fair</i>				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → End Stage Parkinson's Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 13 YRS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Fair</i>				29c. LICENSE NUMBER D23450		29d. DATE SIGNED (Month, Day, Year) 3/7/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3346 PAPERMILL RD PATERIA MD 21131							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE <i>John D. Fair</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 06706

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ANNA ELZA

2. Date of Death

Month Day Year
MARCH 7 1996

3. Time of Death

4:10 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview M.C.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

226-10-6770

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr 29, 1912

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2912 Yorkway

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles H. Smiley

18. Mother's Name (First, Middle, Maiden Surname)

Virgie L. Plecker

19a. Informant's Name/Relationship (Type, Print)

June Elza / daughter in law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2912 Yorkway Baltimore, Md 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial

Date

3/11

20c. Location - City or Town, State

Elkridge, Md

21. Signature of Funeral Service Licensee

Anthony Colt Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk

7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. ASPIRATION EVENT

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. C. H. Meyer, M.D.

29c. License number

046547

29d. Date signed (Month, Day, Year)

March 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLEN MEYERS - 4940 EASTERN AVE, BALTIMORE, MD 21227

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

Lia Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06707

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CORA FISHER

Cora May Fisher

2. Date of Death

FEB 25 1996

3. Time of Death

7:01 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BON SECURE HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-20-7861

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11 12 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2605 ROUND ROAD

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

6th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Holtite Rubber Company

17. Father's Name (First, Middle, Last)

RUSE FISHER

18. Mother's Name (First, Middle, Maiden Surname)

Catherine PRADEN

19a. Informant's Name/Relationship (Type, Print)

Gwendolyn Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2846 Bockert Drive Baltimore Md 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

3/2/96

20c. Location - City or Town, State

Baltimore Md

21. Signature of Funeral Service Licensee

Jenny Harris

22. Name and Address of Facility

CHATHAM - Annis Funeral Home

5540 Rustentown Rd Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic renal failure

Due to (or as a consequence of):

b. Congestive heart failure

Due to (or as a consequence of):

c. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Paget's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Julianne Barsony BSH

29c. License number

D 44091

29d. Date signed (Month, Day, Year)

Feb 25/1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. JULIANNA BARSONY BSH

31. Date filed (Month, Day, Year)

MAR 08 1996

32. Registrar's Signature

John A. Russell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06708

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hattie Lucille Frazier

2. Date of Death

FEB 27 1996

3. Time of Death

4:15P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1223 N. Gilmore Street

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

323-24-7199

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 18 1929

9. Birthplace (State or Foreign Country)

Kentucky

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1223 N. Gilmore Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

Dietary Aide

Dietary Aide

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietary Aide

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

William Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Miller

19a. Informant's Name/Relationship (Type, Print)

Linda Christian, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4828 Valley Forge Road Randallstown, Md 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Rest

Date

3/2/96

20c. Location - City or Town, State

Towson, Md

21. Signature of Funeral Service Licensee

George W. Kelley

22. Name and Address of Facility

CHAIRMAN - HORN'S Funeral Home
5540 Rosterdown Road Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Metastatic cancer of pancreas

Approximate Interval Between Onset and Death

6 months

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NIDDM

pancreatic insufficiency

chronic lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George W. Kelley

29c. License number

D16189

29d. Date signed (Month, Day, Year)

2-29-96

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

GEORGE N. KALKAR MD. PA

6525 N. Chalk St Suite 615
TOWSON MD 21204

31. Date filed (Month, Day, Year)

MAR 1 8 1996

32. Registrar's Signature

L. J. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06709

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA M. FRITSCH

2. Date of Death

Month
MARCH

Day

6

Year

1996

3. Time of Death

10:50 am

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-16-4605

8. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 31, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3310 Dudley Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th Grade

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Emil Frey

18. Mother's Name (First, Middle, Maiden Sumame)

Anna Yonder

19a. Informant's Name/Relationship (Type, Print)

Anna M. Aumiller (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd, Walden Ct., Apt 1504, Balto, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

3/8/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

037016

29d. Date signed (Month, Day, Year)

3/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7801 York Rd. Suite 101 Towson, MD 21204

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[illegible]

96 06710

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marjorie Goldsborough Griffin				2. DATE OF DEATH MONTH DAY YEAR March 6 1996				3. TIME OF DEATH 2:30 A M	
4. SOCIAL SECURITY NUMBER 216-12-3028		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 22, 1921		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 4513 Elmer Derr Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3925 Beech Ave.				10f. ZIP CODE 21210		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) College (1-4 or 5+) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Charles Reubell Goldsborough, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helena Rhodes					
19a. INFORMANT'S NAME (Type/Print) Christopher Griffin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4513 Elmer Derr Rd. Frederick, MD 21701					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery		DATE 3/7		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John O. Mitchell IV				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cachexia DUE TO (OR AS A CONSEQUENCE OF): b. Diffuse metastatic spread of squamous cell carcinoma of anal verge DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. enterovaginal fistula								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Son's Home							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Frank R. Claude, MD				29c. LICENSE NUMBER D26438		29d. DATE SIGNED (Month, Day, Year) 3/6/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK R. CLAUDE, MD 821 Eutan St. Balto md 21201									
31. DATE FILED (Month, Day, Year) MAR 8 1996		32. REGISTRAR'S SIGNATURE [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 06711

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PETER J. GERST				2. DATE OF DEATH MONTH DAY YEAR MARCH 4, 1996		3. TIME OF DEATH 6:50 AM	
4. SOCIAL SECURITY NUMBER 215-12-1488		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 2, 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) RIVERVIEW NURSING CENTRE, INC.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION White Marsh		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 333		10f. ZIP CODE 21162		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		15b. KIND OF BUSINESS/INDUSTRY Auto Body Shop			
17. FATHER'S NAME (First, Middle, Last) Jacob J. Gerst				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary C. Kahl			
19a. INFORMANT'S NAME (Type/Print) Katherine M. Furnkas (niece)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 333, White Marsh, MD 21162			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. DATE 3/7		20d. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal and Hepatic Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { Myocardial Infarction Arteriosclerotic Coronary Vascular Disease d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. old cerebrovascular accident dementia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D19667		29d. DATE SIGNED (Month, Day, Year) 3-4-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MICHAEL SCHWARTZ 606 HAMMONDS LANE 21225							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06712

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY GAINES

2. Date of Death

MARCH 06, 1996

3. Time of Death

0731 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2910 REISTERSTOWN ROAD APT. #202

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220-12-7213

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 20, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

10a. State

N/A

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2910 Reisterstown Rd. APT. 202

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Negro

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

Howard Ellison

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth DeShields

19a. Informant's Name/Relationship (Type, Print)

Saundra Washington

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3611 Bellmore Rd. Balto. Md. 21244

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount

Date

3/12/96

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?

INSPECTION

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Physician or
Medical Examiner)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Laron Locke M.D.

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MARCH 06, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 08 1996

32. Registrar's Signature

J. Laron Locke

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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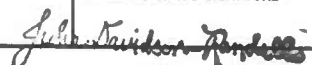
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96 06713

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ESTHER GOOZH				2. DATE OF DEATH MONTH 3 DAY 01 YEAR 96		3. TIME OF DEATH 6:55 A M	
4. SOCIAL SECURITY NUMBER 578-18-1321		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1-28-09	
8. FACILITY NAME (If not institution, give street and number) POTOMAC VALLEY NURSING CENTER				9a. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1617 Hugo Circle				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Person		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Jacob Goozh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Lesnick			
19a. INFORMANT'S NAME (Type/Print) Paul Goozh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 Hugo Circle, Silver Spring, Md 20906			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Mem. Grdn. 3/4/96		20c. LOCATION — City or Town, State Olney, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Va 22046			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bowel Obstruction DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma of Colon DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 48° 1 yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardiovascular Disease Hypertension							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) March 1, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shumacher MD 2309 Shorefield Rd Wheaton, MD 20902							
31. DATE FILED (Month, Day, Year) JAN 08 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

611

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Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD COOPER GOLDMAN				2. Date of Death Month Day Year MARCH 02, 1996		3. Time of Death 2215PM					
	4a. Facility Name (If not institution, give street and number) 14405 NADINE DRIVE				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 219-64-7239		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 22, 1955					
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Montgomery		10c. City, Town or Location 14405 Nadine Drive, Rockville					
Usual Residence of Decedent												
10a. State MD			10b. County Montgomery			10c. City, Town or Location 14405 Nadine Drive, Rockville						
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number 14405 Nadine Drive			10f. Zip Code 208		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1975-78			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales			16b. Kind of Business/Industry Retail						
17. Father's Name (First, Middle, Last) Dorrel Goldman					18. Mother's Name (First, Middle, Maiden Surname) Edna Cooper							
19a. Informant's Name/Relationship (Type, Print) Edna Goldman					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1850 NE 48th Street, Pompano Beach FL 33064							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.			Date 3/7/96		20c. Location - City or Town, State Cheltenham, MD				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) FOUND: 3/2/96		28b. Time of Injury 8:00 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME						28f. Location (Street and Number or Rural Route Number, City or Town, State) 14405 NADINE DRIVE ROCKVILLE, MARYLAND			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and Title of certifier 			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) MARCH 03, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) MAR 12 1996			32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06715

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Howard

2. Date of Death
Month Day Year

3

6

96

3. Time of Death

10:15 Am

4a. Facility Name (If not Institution, give street and number)

936 E. Preston St

4b. City, Town, or Location of Death

Baito

4c. County of Death

N.A.

Funeral
Director

5. Social Security Number

219 26 6563

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

7-29-39

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N.A.

10c. City, Town or Location

Baito

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

936 E. Preston St

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4or 5+)

N.A.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cutter

16b. Kind of Business/Industry

Wendell Clothiers

17. Father's Name (First, Middle, Last)

Charles Howard

18. Mother's Name (First, Middle, Maiden Surname)

Grace Webb

19a. Informant's Name/Relationship (Type, Print)

Edith Howard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 E. LANVALE ST - Baito, Md 21213

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Western Star Cem

Date

3/11/96

20c. Location - City or Town, State

Catonville, Md

21. Signature of Funeral Service Licensee

Joseph B. Locks Jr

22. Name and Address of Facility

Locks Funeral Home 1304 N. Central Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Arrhythmia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 day

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Hyperkalemia
Due to (or as a consequence of):

4 years

c. Chronic myelocytic leukemia
Due to (or as a consequence of):

6 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy
Urate Nephropathy
Emphysema

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide☐ Pending
investigation
☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel J. George

29c. License number

D47550

29d. Date signed (Month, Day, Year)

3/7/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DANIEL J. George

31. Date filed (Month, Day, Year)

JAN 08 1996

32. Registrar's Signature

Julia Harrison-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06716

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise Charlotte Hall				2. Date of Death Month March Day 6 Year 1996		3. Time of Death 12:05am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-03-1821		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 18, 1919	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 346 Savannah Road				10f. Zip Code 21221		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Charles Luebben				18. Mother's Name (First, Middle, Maiden Surname) Louise Sattler				
19a. Informant's Name/Relationship (Type, Print) James Pollard Hall				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 346 Savannah Road Baltimore Md. 21221				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 3/9/96		20c. Location - City or Town, State Baltimore Md.		
21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death ~ 1 HOUR ~ 10 YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Essential Renal Insufficiency								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John H. [Signature]		29c. License number D15022		29d. Date signed (Month, Day, Year) 3/7/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8552 PHILADELPHIA RD., BALTIMORE, MD 21237								
31. Date filed (Month, Day, Year) MAR 8 1996		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06717

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) HENRIETTE HARTMANN				2. Date of Death Month MARCH Day 5 Year 1996		3. Time of Death 12:15 P.M.	
4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL CONVALESCENT CENTER				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 564-05-8987		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 25 1901	
9. Birthplace (State or Foreign Country) GERMANY							
Usual Residence of Decedent							
10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location GIBSON ISLAND				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number SKYWATER DRIVE		10f. Zip Code 21056		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 7		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FREE LANCE		16b. Kind of Business/Industry ARTIST	
17. Father's Name (First, Middle, Last) GEORGE FARBER -				18. Mother's Name (First, Middle, Maiden Surname) TERESA LIST			
19a. Informant's Name/Relationship (Type, Print) GEORGE FARBER - BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 WEST JOPPA ROAD, TOWSON, MD 21204			
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC.		Date 3-6-1996		20c. Location - City or Town, State BALTIMORE, MD	
21. Signature of Funeral Service Licensee HILARY E. STALLINGS, JR.				22. Name and Address of Facility STALLINGS FUNERAL HOME, P.A. 3111 MOUNTAIN ROAD, PASADENA, MD 21122			
23a. Part I. Enter the disease, or complications met caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Heart Disease Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death years years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic vascular foot						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Salvacion A. Dupaya		29c. License number P38912		29d. Date signed (Month, Day, Year) 3/06/96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SALVACION DUPAYA, M.D., 1720 CRAIN HIGHWAY, GLEN BURNIE, MD 21061							
31. Date filed (Month, Day, Year) MAR 0 8 1996		32. Registrar's Signature J. A. [Signature]					

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06718

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN DENISON HEATON				2. Date of Death Month MARCH Day 6 , Year 1996		3. Time of Death 2:25 a	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 522-44-1103	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR 6, 1933		9. Birthplace (State or Foreign Country) Vermont
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1319 Park Avenue				10f. Zip Code 21217		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Family Law		
	17. Father's Name (First, Middle, Last) William George Morison				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Denison			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Glenn Earl Heaton/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Park Avenue Baltimore, MD 21217			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/07/96		Date 03/07/96		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee <i>Dawn F. McDonald</i> Dawn F. McDonald				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. non-small cell lung cancer with lung, brain and pancreas metastases Due to (or as a consequence of): b. lung, brain and pancreas metastases Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. atrial fibrillation esophageal mucositis				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Rainer Brachmann M.D.</i>				29c. License number 20372		29d. Date signed (Month, Day, Year) 3/6/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rainer Brachmann M.D. Johns Hopkins Onc Center, Baltimore							
31. Date filed (Month, Day, Year) MAR 0 8 1996				32. Registered Signature <i>Johanna Brachmann</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

REG. NO.

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

67



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Filmg, 733, item #1, 3/8/96,cyw
Certificate of Death

96 06720

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEONOR MONTE Jackson					2. Date of Death Month Feb Day 25 Year 96		3. Time of Death 00:40		
	4e. Facility Name (If not institution, give street and number) LIBERTY MEDICAL Center					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-32-4566		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) JAN 9, 1917		9. Birthplace (State or Foreign Country) PHILIPPINES	
	Usual Residence of Decedent					10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE
								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 5320 NELSON AVENUE		10f. Zip Code 21215		10g. Citizen of What Country? USA				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECHNICIAN		16b. Kind of Business/Industry LINEN DEPT / GBMC				
		17. Father's Name (First, Middle, Last) SUTURNINO MONTE		18. Mother's Name (First, Middle, Maiden Surname) ROMANA ESPLANADA						
		19a. Informant's Name/Relationship (Type, Print) CHRISTOPHER C. JACKSON SR.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5320 NELSON AVE BALTIMORE, MD 21215						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Mt. Cem.		20c. Location - City or Town, State Durays Mills, MD				
		21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CHAIRMAN - Harris P.L. Baltimore, MD 21215						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. HABEUI Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Stroke Atrial Fibrillation		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		
				28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier G. C. Jackson, MD		29c. License number DD4826		29d. Date signed (Month, Day, Year) 2/25/96		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO C. MARTORI LIBERTY MEDICAL CENTER								
		31. Date filed (Month, Day, Year) MAR 08 1996		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

96 06721

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MABEL EVELYN JOYNER		2. Date of Death Month FEB Day 29 Year 1996		3. Time of Death 6:00 A	
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL HOSPITAL ER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 241-52-7350	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEP 23, 1934
	9. Birthplace (State or Foreign Country) U. Carolina					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Maryland	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2223 N. Dukeland Street		10f. Zip Code 21216		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk Typist II		16b. Kind of Business/Industry JOHNS HOPKINS Hospital			
	17. Father's Name (First, Middle, Last) ROBERT E. JOYNER		18. Mother's Name (First, Middle, Maiden Surname) LUSA SPELL			
	19a. Informant's Name/Relationship (Type, Print) MARSHA JOYNER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2223 N. Dukeland Street Baltimore, MD 21216			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY		20c. Location - City or Town, State BALTIMORE MD	
	21. Signature of Funeral Service Licensee Gray Davis		22. Name and Address of Facility CHA Max - Harris R. H. 5540 Reisterstown Road Baltimore, MD 21215			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
	Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CANCER OF LEFT BREAST					
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
State Registrar	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dennis J. Chute MD		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) FEBRUARY 29, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) MAR 08 1996		32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Filing, 733, item #1, 3/8/96, cyw, periph
4c.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06722

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERIC EMIL JONSKE

2. Date of Death

Month
3

Day
5

Year
96

3. Time of Death

0139

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Systems

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N.A.

Baltimore

Funeral
Director

5. Social Security Number

213-14-8699

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
July 8, 1908

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9659 Dundawan Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Welding Company

17. Father's Name (First, Middle, Last)

Herman L. Jonske

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Scholz

19a. Informant's Name/Relationship (Type, Print)

Josephine Jonske (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9659 Dundawan Road, Baltimore, MD 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

3/9/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schmunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Thoracic Aortic Aneurysm

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

16hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]
Yvonne Fenner, MD

29c. License number

P08185

29d. Date signed (Month, Day, Year)

3/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yvonne Fenner, MD UMMS Dept of Anesthesiology Baltimore, MD

State
Registrar

31. Date filed (Month, Day, Year)

MAR 08 1996

32. Registrar's Signature

[Signature]
Julia Davidson-Rendell

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1947

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation.

3. The third part of the report is devoted to a detailed analysis of the social situation.

4. The fourth part of the report is devoted to a detailed analysis of the political situation.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation.

96 06723

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANDREW Z. KELLER				2. DATE OF DEATH MONTH Feb DAY 15 YEAR 1996		3. TIME OF DEATH 6:15 A M	
4. SOCIAL SECURITY NUMBER 412-38-5811		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) Oct. 4, 1927	
8. BIRTHPLACE (State or Foreign Country) unknown				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Dist. of Columbia		10b. COUNTY unknown	
10c. CITY, TOWN OR LOCATION Washington				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 36 Madison Street, N.E.	
10f. ZIP CODE 20011				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES unknown				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown		16b. KIND OF BUSINESS/INDUSTRY Veterans Administration	
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) (daughter) Andreia Keller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1125 5th St. N.E.-Apt. 2-Washington, D.C. 20011			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) In State rem.				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade Dir. 7-20-96				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → STROKE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): c. Possible Cytomegalovirus encephalitis DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cytomegalovirus Retinitis Sarcoidosis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Michael J. Furlong				29c. LICENSE NUMBER 039-838		29d. DATE SIGNED (Month, Day, Year) 7-15-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael J. FURLONG MD							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE Glenn R. Radell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06724

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lauri Erik Kolstrom

2. Date of Death

Month Day Year
March 7 1996

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

816 S. 50 th Street

4b. City, Town, or Location of Death

N/A

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-07-3677

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 27, 1912

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

816 S. 50 th Street

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Wire Drawer

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Albert Kolstrom

18. Mother's Name (First, Middle, Maiden Surname)

Hanna Housula

19a. Informant's Name/Relationship (Type, Print)

Peter L. Kolstrom

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

816 S. 50 th Street Baltimore, Md 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

3/8/96

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee

Anthony Colt Connolly

22. Name and Address of Facility

Connolly Funeral Home of Dundalk
7110 Sollers Point Rd 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

b. Alzheimer's disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 wks
2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

D11455

29d. Date signed (Month, Day, Year)

3/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gustav C. Voigt, M.D. 2112 Dundalk Ave Baltimore, Md 21222

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

Julia [Signature]

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06725

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret E. LYNN

2. Date of Death
Month Day Year

March 1, 1996

3. Time of Death

9:10 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

N/A

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

191-12-4925

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 15, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3919 Lyndale Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Basilica Place

17. Father's Name (First, Middle, Last)

David Lynn

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Price

19a. Informant's Name/Relationship (Type, Print)

Margaret I. Kasten (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3919 Lyndale Ave., Baltimore, Maryland 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount Crematory 3/4/96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 2121323a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

1 Day

b. Lymphoma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Arrhythmia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Marie Chatham M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 0 8 1996

Julia Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06726

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy

LEE

2. Date of Death

Month Day Year
March 3, 1996

3. Time of Death

8:30 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore County

5. Social Security Number

220-03-6614

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 28, 1908

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1 Eastern Ave.

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Companion

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

John Owens

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Griffiths

19a. Informant's Name/Relationship (Type, Print)

William E. Owens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 Maiden Choice Lane Catonsville Md. 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery 3/11/96

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia, Right lower and middle lobes

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Marked cachexia

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

P64-1

29c. License number

2338412918

29d. Date signed (Month, Day, Year)

03/04/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melanye Maclin, M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

J. H. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6. The first part of the report is devoted to a general survey of the situation in the country.

The second part of the report is devoted to a detailed analysis of the economic situation.

The third part of the report is devoted to a detailed analysis of the social situation.

The fourth part of the report is devoted to a detailed analysis of the political situation.

The fifth part of the report is devoted to a detailed analysis of the cultural situation.

The sixth part of the report is devoted to a detailed analysis of the international situation.

The seventh part of the report is devoted to a detailed analysis of the future prospects.

The eighth part of the report is devoted to a detailed analysis of the conclusions.

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Filmg, 733, item #1, 3/8/96,cyw, per fh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06727

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNE EVELYN LOWRIE LAWRIE		2. Date of Death Month Day Year MARCH 6, 1996		3. Time of Death 10:30 P.M.
	4a. Facility Name (If not institution, give street and number) 714 SEAGROVE ROAD		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 218-28-4198	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) 03/22/1922	9. Birthplace (State or Foreign Country) CANADA
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 714 SEAGROVE ROAD		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: UNKNOWN
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING AIDE		16b. Kind of Business/Industry NURSING FACILITY		
	17. Father's Name (First, Middle, Last) UNKNOWN		18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN		
	19a. Informant's Name/Relationship (Type, Print) BASCOMB WILLIS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 MAPLE LANE N.W., GLEN BURNIE, MARYLAND 21061		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK CEMETERY		20c. Location - City or Town, State 3/11/96 WOODLAWN, MARYLAND
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>a. <u>Hypertension angina</u> Due to (or as a consequence of):</p> <p>b. <u>Lung mass</u> Due to (or as a consequence of):</p> <p>c. <u>pulmonary Emboli</u> Due to (or as a consequence of):</p> <p>d. <u>Rheumatoid Arthritis</u></p>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerosis</u> <u>Hiatal Hernia</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <u>Mustafa Cam Sun</u>		29c. License number D 22206		29d. Date signed (Month, Day, Year) 3.7.96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MUSTAFA C. OZ MD 273 peninsula farm rd. Annapolis, MD 21012</u>					
31. Date filed (Month, Day, Year) MAR 08 1996		32. Registrar's Signature <u>John Davidson-Rendell</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06728

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM RICHARD LAYMAN

2. Date of Death

Month
MARCH

Day

7

Year

1996

3. Time of Death

4:38 A.M.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL NURSING & CONVALESCENT CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

236-12-8498

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
OCT 25 1916

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

108 SUNRISE LANE

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK MECHANIC

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

WILLIAM LAYMAN

18. Mother's Name (First, Middle, Maiden Summa)

FRANKIE RUSH

19a. Informant's Name/Relationship (Type, Print)

DAVID LAYMAN - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 SUNRISE LANE, GLEN BURNIE, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FLEMINGTON I.O.O.F. CEM.

Date

3-11-96

20c. Location - City or Town, State

FLEMINGTON, WV

21. Signature of Funeral Service Licensee

HILARY L. STALLINGS, JR.

22. Name and Address of Facility

STALLINGS FUNERAL HOME, P.A.
3111 MOUNTAIN ROAD, PASADENA, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Approximate Interval Between Onset and Death

2 Years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William R. Layman, M.D., Attending Doctor

29c. License number

D21684

29d. Date signed (Month, Day, Year)

3-8-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. V. CYRIAC, M.D., 1600 SOUTH CRAIN HIGHWAY, GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

Jahia D. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

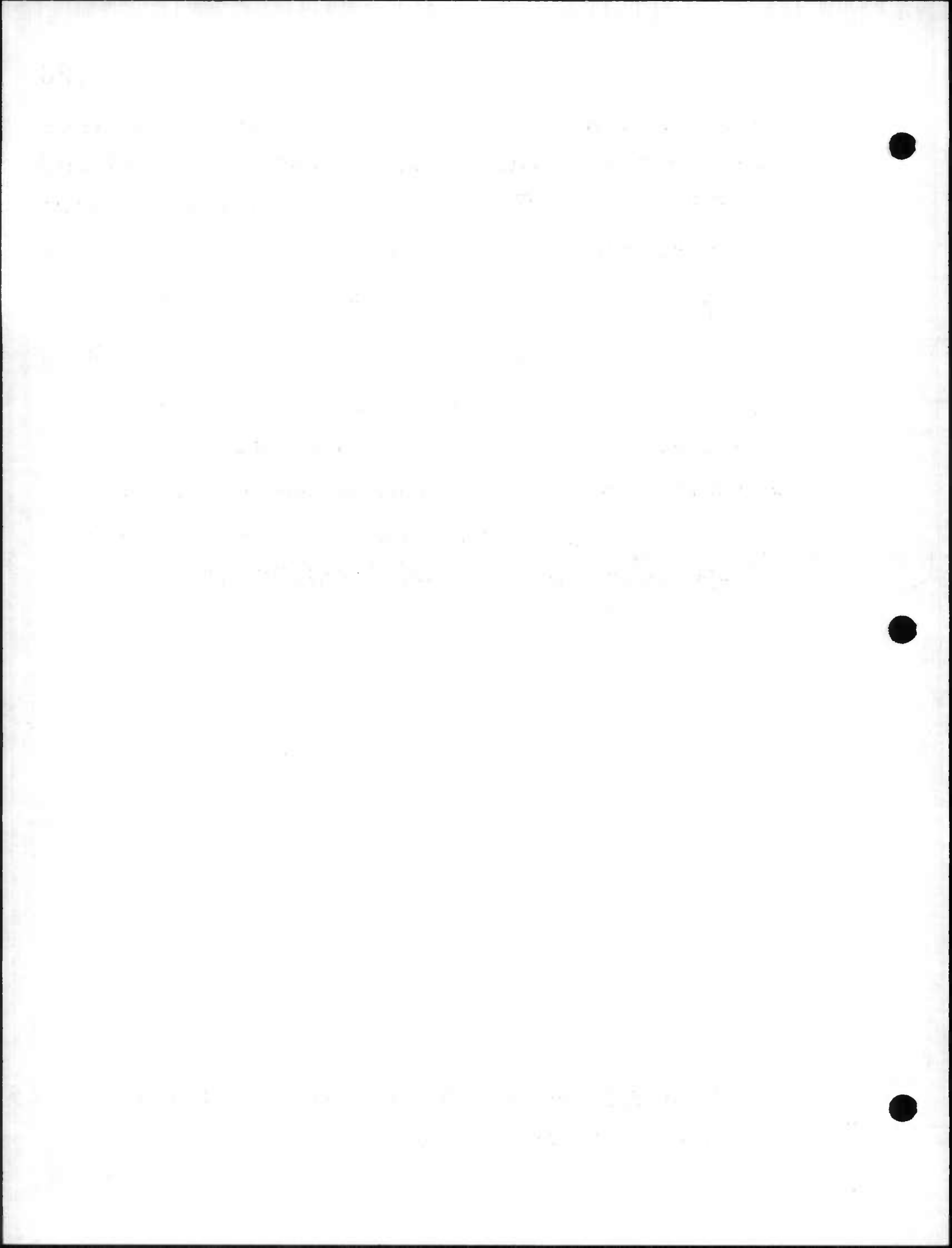
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06729

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>NANNIE B. MURRAY</u>				2. Date of Death Month <u>3</u> Day <u>2</u> Year <u>96</u>		3. Time of Death <u>8:30A</u>	
	4a. Facility Name (If not institution, give street and number) <u>INNS OF EVERGREEN Northwest</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>219-22-2857</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>7 18 08</u>	
	9. Birthplace (State or Foreign Country) <u>NC</u>		10a. State <u>md.</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore City</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <u>1</u> Yes <u>2</u> No				10e. Street and Number <u>435 E. LANUKE ST.</u>		10f. Zip Code <u>21202</u>	
	10g. Citizen of What Country? <u>USA</u>				11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>Collage (1-4or 5+)</u>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>DOMESTIC WORKER</u>				16b. Kind of Business/Industry <u>Private family</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Unknown</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Unknown</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Michael Coleman, Grandson</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4925 Springhill Dr. Pensacola, Florida 32503</u>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Crownsville Vet's Cemetery</u>			
	20c. Location - City or Town, State <u>31796 Crownsville, Md.</u>				21. Signature of Funeral Service Licensee <u>Spangham</u>			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <u>Chatman-Harris Funeral Home</u> <u>5240 Reisterstown Rd. Balto. Md. 21215</u>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Oxygenic Brain Syndrome</u>			
	23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown				24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No				25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No			
	26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)				27. Manner of Death <u>1</u> Natural <u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide <u>5</u> Pending investigation <u>6</u> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year) <u>3/6/96</u>				28b. Time of Injury <u>M</u>			
	28c. Injury at Work? <u>1</u> Yes <u>2</u> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of Certifier <u>MD</u>			
To Be Completed by Physician/Medical Examiner	29c. License number <u>D27569</u>				29d. Date signed (Month, Day, Year) <u>3/6/96</u>			
	30. Name and address of person who completed cause of death (item 23a) (Type, Print) <u>Allen Rottman 1777 Reisterstown Rd #365</u>				31. Date filed (Month, Day, Year) <u>MAR 6 8 1996</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>CAROLYN M. Mulford</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>1</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>11:25 AM</i>	
4. SOCIAL SECURITY NUMBER <i>214-30-2798</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in years - last birthday) <i>63</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 7, 1932</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Southern Maryland Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton</i>		9c. COUNTY OF DEATH <i>Prince Georges</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1538 Upshire Road</i>			
10f. ZIP CODE <i>21218</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12th Grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Owner</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Kiper's Grocery Store</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Peter Kiper</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mamie Wojchiehowski</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Thomas Mulford Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8331 Tally Ho Road, Lutherville, Md. 21093</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holy Rosary Cemetery 3/5/96</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. VENTRICULAR Fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>b. CORONARY HEART DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate interval Between Onset and Death <i>< 1 hr.</i> <i>years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>s/p quadruple coronary Artery bypass revascular, 3 wks ago</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i>				29c. LICENSE NUMBER <i>D25925</i>		29d. DATE SIGNED (Month, Day, Year) <i>March 1, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>J. BERGER MD #205 7720 Wisconsin Ave Bethesda, Md 20814</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 08 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06731

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy G. Meginniss				2. DATE OF DEATH MONTH March DAY 5 , YEAR 1996		3. TIME OF DEATH 8:45 A. M	
4. SOCIAL SECURITY NUMBER 213-28-3145		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 28, 1909	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 114 Overbrook Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 114 Overbrook Road	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Investigative Secretary		16b. KIND OF BUSINESS/INDUSTRY Government	
17. FATHER'S NAME (First, Middle, Last) Charles H. Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Bryant			
19a. INFORMANT'S NAME (Type/Print) Barbara A. Kerr (grand-daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Tanglewood Court, Joppatowne, MD 21085			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hopewell Cem of Cecil County 3/8 Port Deposit, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. Coronary artery disease							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D22937 MD		29d. DATE SIGNED (Month, Day, Year) 3/7/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) St Joseph Prof. Bldg. 7401 Eastern Ave. Towson, MD 21204							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


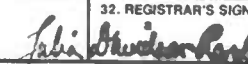
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06732

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BETSY Broadway MAYO				2. DATE OF DEATH MONTH March DAY 5 YEAR 1996		3. TIME OF DEATH 12:30 P M	
4. SOCIAL SECURITY NUMBER 219-84-4762		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS 5 DAYS 17	IF UNDER 24 HRS. HOURS 12 MIN. 30	7. DATE OF BIRTH (Month, Day, Year) 8-21-1959	
8. BIRTHPLACE (State or Foreign Country) New Jersey				9a. FACILITY NAME (If not institution, give street and number) 17 South Rosedale St.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Md.		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 17 South Rosedale St.	
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Line Worker		15b. KIND OF BUSINESS/INDUSTRY Cosmetic Noxell Corporation			
17. FATHER'S NAME (First, Middle, Last) Unknown				16. MOTHER'S NAME (First, Middle, Maiden Surname) Wilma Broadway			
19a. INFORMANT'S NAME (Type/Print) Ruth H. Palmer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 South Rosedale St. Balto., Md. 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park		DATE 3-9		20c. LOCATION — City or Town, State Woodlawn, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Caple Funeral Services 5502 Winner Ave. Balto., Md. 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. sarcoidosis DUE TO (OR AS A CONSEQUENCE OF): b. Chronic bronchitis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Roy Habib M.D.				29c. LICENSE NUMBER PO 7536		29d. DATE SIGNED (Month, Day, Year) March 5/1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROY HABIB SAINT AGNES HOSPITAL 900 CATON AVE BALTIMORE MD 21229							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06733

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ANN ELIZABETH NORTON</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>5</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>3:00 P</u> <u>M</u>	
4. SOCIAL SECURITY NUMBER <u>212-32-6744</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>60</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Jan. 3, 1936</u>	
8a. FACILITY NAME (If not Institution, give street and number) <u>3 York Court #1</u>				8b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>		8c. COUNTY OF DEATH <u>N/A</u>	
9a. STATE <u>Maryland</u>		9b. COUNTY <u>N/A</u>		9c. CITY, TOWN OR LOCATION <u>Baltimore City</u>		9d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STREET AND NUMBER <u>3 York Court #1</u>				10f. ZIP CODE <u>21218</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Director of Ambulatory Care</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Medical</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Thomas Joseph Norton</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ellen Marie Hughes</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mr. James J. Norton</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3405 Oakenshaw Pl., Baltimore, Maryland</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Green Mount Crematory</u>		DATE <u>3/7</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Martin D. Lawson</u>				22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Wiedefeld Home</u> <u>6500 York Road, Baltimore, Maryland 21212</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Metastatic breast cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Katherine Tkaczuk</u>				29c. LICENSE NUMBER <u>D36146</u>		29d. DATE SIGNED (Month, Day, Year) <u>3/6/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Katherine Tkaczuk, M.D., 22 S. Greene Street, Baltimore, Maryland 21201</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 08 1996</u>				32. REGISTRAR'S SIGNATURE <u>Jebbie Anderson</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



THE UNIVERSITY OF CHICAGO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06734

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) EDNA NEUBY				2. Date of Death Month MARCH Day 2 Year 1996				3. Time of Death 4:18 AM	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N. A.	
Funeral Director	5. Social Security Number 219 22 6578A	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/7/19		9. Birthplace (State or Foreign Country) VA		
	Usual Residence of Decedant									
To Be Completed by Funeral Director	10a. State MD.		10b. County N. A.		10c. City, Town or Location BALTO.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2517 E. Biddle St				10f. Zip Code 21213		10g. Citizen of What Country? U.S. A			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK			16b. Kind of Business/Industry St. Catherine School		
	17. Father's Name (First, Middle, Last) Wm. Bridgforth				18. Mother's Name (First, Middle, Maiden Surname) ELIANA JONES					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JONATHAN P. NEUBY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 E. Biddle St BALTO: MD 21213					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garwood Forest		Data 3/7/96		20c. Location - City or Town, State Orwings Mills, Md			
	21. Signature of Funeral Service Licensee Joseph G. Locks, Jr.				22. Name and Address of Facility Locks Funeral Home 1304 N. Central Ave					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia Due to (or as a consequence of): b. Hypoventilation Due to (or as a consequence of): c. Pulmonary edema Due to (or as a consequence of): d. Acute renal failure. Approximate Interval Between Onset and Death 20 min. 30 min. 1 week 1 mo.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non-traumatic pathologic (B) hip fracture Hypertension Congestive heart failure Rheumatoid arthritis									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Sattler, MD Medicine Housestaff				29c. License number M6279	
	29d. Data signed (Month, Day, Year) March 2, 1996				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sherita Hill Tower 110 Doctor's Lounge Johns Hopkins Hospital Baltimore, MD 21287					
	31. Data filed (Month, Day, Year) MAR 0 8 1996				32. Registrar's Signature Jebidiah Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96-1209-510

CIP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Filmg, 733, item #1, 3/8/96, cyw, per fh

Certificate of Death

Reg. No.

96 06735

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN

E.

NEWELL

2. Date of Death

Month

Day

Year

MARCH 5, 1996

3. Time of Death

3:38AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2613 EAST MONUMENT STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-14-7550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 15, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Marland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2613 E. Monument St.

10f. Zip Code

21205

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10th Grade

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Clerical Worker

16b. Kind of Business/Industry

Social Security

17. Father's Name (First, Middle, Last)

Joseph Ford

18. Mother's Name (First, Middle, Maiden Surname)

Rose Gallagher

19a. Informant's Name/Relationship (Type, Print)

Edward Clay (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

261 11th Street, Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 3/8/96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home Inc.

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Antipositive Cardiac Disease*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner:

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 6, 1996

30. Name and address of person who completed Cause of death (Item 23e) (Type, Print)

THEODORE M. KING M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 08 1996

32. Registrar's Signature

*J. Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 23e or 23f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06736

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD John NEUMANN SR			2. Date of Death Month Day Year MAR. 02 96			3. Time of Death 9:50 AM		
	4a. Facility Name (If not Institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 712-03-0118			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) March 17, 1917	
	9. Birthplace (State or Foreign Country) Colorado			10a. State Maryland			10b. County Montgomery		
To Be Completed by Funeral Director	Usual Residence of Decedent			10c. City, Town or Location Bethesda			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 5101 Ridgely Road			10f. Zip Code 20816			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
	14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		
	16b. Kind of Business/Industry Motorola			17. Father's Name (First, Middle, Last) Edward G. Neumann			18. Mother's Name (First, Middle, Maiden Surname) Margaret Hurley		
	19e. Informant's Name/Relationship (Type, Print) John Neumann - Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 North Woodstrail, McLean, Va. 22102					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery			20c. Location - City or Town, State 3/9/96 Wheat Ridge, Colorado		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility Money & King Vienna Funeral Home, Inc. 171 W. Maple Ave., Vienna, Va. 22180					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. acute myocardial infarction Due to (or as a consequence of): c. Clostridium difficile enterocolitis Due to (or as a consequence of): d. Approximate interval Between Onset and Death 4 days 4 days 5 days								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End-stage Emphysema			23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>[Signature]</i> Lee R. Pennington, MD			29c. License number 021115			29d. Date signed (Month, Day, Year) 3/3/1996			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lee R. Pennington, M.D., 5602 Shields Drive, Bethesda, MD 20817			31. Date filed (Month, Day, Year) JAN 08 1996						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

96 06737

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ethel Nelson</i>				2. DATE OF DEATH MONTH DAY YEAR <i>February 29 1996</i>				3. TIME OF DEATH <i>6 PM</i>					
4. SOCIAL SECURITY NUMBER <i>219-32-2386</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>96</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>June 19, 1899</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH <i>Baltimore City</i>					
RESIDENCE OF DECEDENT													
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore City</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>2211 W. Rogers Avenue</i>				10f. ZIP CODE <i>21209</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Our Home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Eli F. Bull</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Letitia Shaffer</i>									
19a. INFORMANT'S NAME (Type/Print) <i>The Wesley Home</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2211 W. Rogers Avenue, Baltimore, Maryland 21209</i>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery 3/4</i>				20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Hines Carpenter</i>				22. NAME AND ADDRESS OF FACILITY <i>Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland</i>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypotension</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Schick M.D.</i>				29c. LICENSE NUMBER <i>AS2402321659944</i>				29d. DATE SIGNED (Month, Day, Year) <i>February 29 1996</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gary Schick M.D., 2401 West Belvedere Baltimore Maryland 21215</i>													
31. DATE FILED (Month, Day, Year) <i>MAR 08 1996</i>				32. REGISTRAR'S SIGNATURE <i>Johi Hudson-Rodell</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06738

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE PARMENTER				2. DATE OF DEATH MONTH MARCH DAY 2 YEAR 1996		3. TIME OF DEATH 0626 a.m.	
4. SOCIAL SECURITY NUMBER 032-12-8074		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 25, 1916	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE FL		10b. COUNTY Pinellas	
10c. CITY, TOWN OR LOCATION Clearwater				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 19029 US 19N, Unit 15B	
10f. ZIP CODE 34624				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Alex Laakso				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Uljua			
19a. INFORMANT'S NAME (Type/Print) Joanna Beauregard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Sanborn St., Fitchburg, MA 01420			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 3/4		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GASTROINTESTINAL BLEED DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  Mahalati MD				29c. LICENSE NUMBER 89242		29d. DATE SIGNED (Month, Day, Year) 3/2/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KATHY MAHALATI, M.D. c/o MARYLAND GENERAL HOSPITAL							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06739

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary Phipps</i>				2. Date of Death Month <i>3</i> Day <i>7</i> Year <i>1996</i>				3. Time of Death <i>11:20 A.M.</i>					
	4a. Facility Name (If not institution, give street and number) <i>CHESAPEAKE HEALTH CARE</i>				4b. City, Town, or Location of Death <i>ARNOLD</i>				4c. County of Death <i>ANNE ARUNDEL</i>					
Funeral Director	5. Social Security Number <i>006-05-2757</i>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>78</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <i>FEB 23 1918</i>		9. Birthplace (State or Foreign Country) <i>MAINE</i>	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <i>MARYLAND</i>		10b. County <i>ANNE ARUNDEL</i>		10c. City, Town or Location <i>PASADENA</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <i>8028-D ABBEY COURT</i>				10f. Zip Code <i>21122</i>				10g. Citizen of What Country? <i>USA</i>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>KEY PUNCH OPERATOR</i>				16b. Kind of Business/Industry <i>FINANCIAL</i>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>MICHAEL MURRAY</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>MARY JOHNSON</i>									
	19a. Informant's Name/Relationship (Type, Print) <i>BARBARA A. JUBB - DAUGHTER</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1480 LONG POINT ROAD, PASADENA, MD 21122</i>									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>METRO CREMATORY, INC.</i>				Date <i>3-11-96</i>		20c. Location - City or Town, State <i>BALTIMORE, MD</i>			
	21. Signature of Funeral Service Licensee <i>HILARY STALLINGS, JR.</i>				22. Name and Address of Facility <i>STALLINGS FUNERAL HOME, P.A. 3111 MOUNTAIN ROAD, PASADENA, MD 21122</i>									
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	Immediate Cause (Final disease or condition resulting in death) <i>a. Acute Renal Failure</i>													
	Due to (or as a consequence of): <i>b. Diabetes Mellitus</i>													
	Due to (or as a consequence of): <i>c. Diabetes Nephrosclerosis</i>													
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>d.</i>														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Previous Myocardial Infarction</i> <i>Peripheral Vascular Disease</i>														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined														
28a. Date of Injury (Month, Day Year)														
28b. Time of Injury <i>M</i>														
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <i>William M. Attending Doctor</i>														
29c. License number <i>D 21684</i>														
29d. Date signed (Month, Day, Year) <i>3-7-96</i>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>C.V. CYRIAC - M.D. 1600 CRAWFORD AVE #106, GLENBURNIE, MD 21061</i>														
31. Date filed (Month, Day, Year) <i>MAR 0 8 1996</i>														
32. Registrar's Signature <i>Johanna R. Randall</i>														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerState
Registrar

96 06740

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME Myra Margrea M Pittman				2. DATE OF DEATH MONTH DAY YEAR March 5 1996				3. TIME OF DEATH 4:06 A M	
4. SOCIAL SECURITY NUMBER 213-30-2230		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 30, 1934		8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not Institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1629 N. Gay Street				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress/Manager			16b. KIND OF BUSINESS/INDUSTRY Le Fontaine Bleu CATERER		
17. FATHER'S NAME (First, Middle, Last) Marion Pittman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Thurston Ross Marion Pittman					
19a. INFORMANT'S NAME (Type/Print) ELAINE THOMAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 N. Gay Street Baltimore, Md 21213					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 3-8-96			20c. LOCATION — City or Town, State Woodlawn, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY 5240 REISTERSTOWN ROAD CHATELAIN-HARRIS F.H. BALTIMORE, MD 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. sepsis syndrome DUE TO (OR AS A CONSEQUENCE OF): b. gastrointestinal bleed DUE TO (OR AS A CONSEQUENCE OF): c. non small cell lung carcinoma with metastasis DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 36 hrs 36 hrs Longer									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED			28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Sherri Lewis-Stevenson MD					
				29c. LICENSE NUMBER AT2438946			29d. DATE SIGNED (Month, Day, Year) 3/5/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sherri Lewis-Stevenson Union Memorial Hospital Baltimore, Md.									
31. DATE FILED (Month, Day, Year) MAR 08 1996				32. REGISTRAR'S SIGNATURE John A. [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06741

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patricia Bea Pompilo				2. DATE OF DEATH MARCH 7 DAY 1996 YEAR				3. TIME OF DEATH 5:30 A M	
4. SOCIAL SECURITY NUMBER 287-24-8857		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 14, 1929		8. BIRTHPLACE (State or Foreign Country) Nebraska	
9a. FACILITY NAME (If not institution, give street and number) 4314 Roland Springs Drive				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH N/A		
10a. STATE Maryland			10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4314 Roland Springs Drive				10f. ZIP CODE 21210		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES:		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Psychologist			16b. KIND OF BUSINESS/INDUSTRY Hearing & Speech Agency			
17. FATHER'S NAME (First, Middle, Last) Ernest Roper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Kaps					
19a. INFORMANT'S NAME (Type/Print) Peter Terrance Pompilo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4314 Roland Springs Dr. Baltimore, MD 21210					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/08/96		20c. LOCATION — City or Town, State Baltimore, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Squamous Cell Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 8 months									
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Dawn M. Hahn MD				29c. LICENSE NUMBER 020396		29d. DATE SIGNED (Month, Day, Year) March 7, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dawn M. Hahn MD 5801 Loch Raven Blvd B. H. MD 21234									
31. DATE FILED (Month, Day, Year) MAR 0 8 1996		32. REGISTRAR'S SIGNATURE John D. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06742

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WESLEY H. ROBERTS

2. Date of Death

FEB. 27 1996

3. Time of Death

11:30A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1846 Division Street

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-14-9445

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 10, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1846 Division Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) Collage (1-4or 5+)

12th GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEXTON

16b. Kind of Business/Industry

ST. MICHAEL'S AND All Angels Church

17. Father's Name (First, Middle, Last)

THEODORE ROBERTS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

EMMA NICHOLS

19a. Informant's Name/Relationship (Type, Print)

Dwendolyn Roberts, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

275 Boulton St. SAN FRANCISCO, CA 94134

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Park

Date

3/4/96

20c. Location - City or Town, State

Timonium, Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATEAU - Hospist.H. Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Hours

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Years

Due to (or as a consequence of):

c. Cardiac Arrhythmia

Years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

[Signature] Vasantha Kumar MD

29c. License number

D42510

29d. Date signed (Month, Day, Year)

02/29/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. VASANTHA KUMAR, SRI N. EUTAW ST, SUITE 407, MD 21201.

State
Registrar

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06743

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Dianne

RAWLINGS

2. Date of Death

Month Day Year
March 6, 1996

3. Time of Death

6:42 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore County

5. Social Security Number

215-40-9983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 28, 1943

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 Landmark Court

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

17. Father's Name (First, Middle, Last)

Harry Hatch

18. Mother's Name (First, Middle, Maiden Surname)

Glwendolyn McMarigal

19a. Informant's Name/Relationship (Type, Print)

Chebon L. Grayson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2706 Bayonne Ave. Baltimore Md. 21214

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

crematory, crematory or other place)

Metro Crematory Inc. 3/7/96

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Opportunistic infection/Sepsis

Due to (or as a consequence of):

19 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Human Immunodeficiency Virus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Joseph

29c. License number

D47529

29d. Date signed (Month, Day, Year)

March 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Joseph, M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

John D. ...

State
Registrar

Baltimore, Maryland 21215-0020

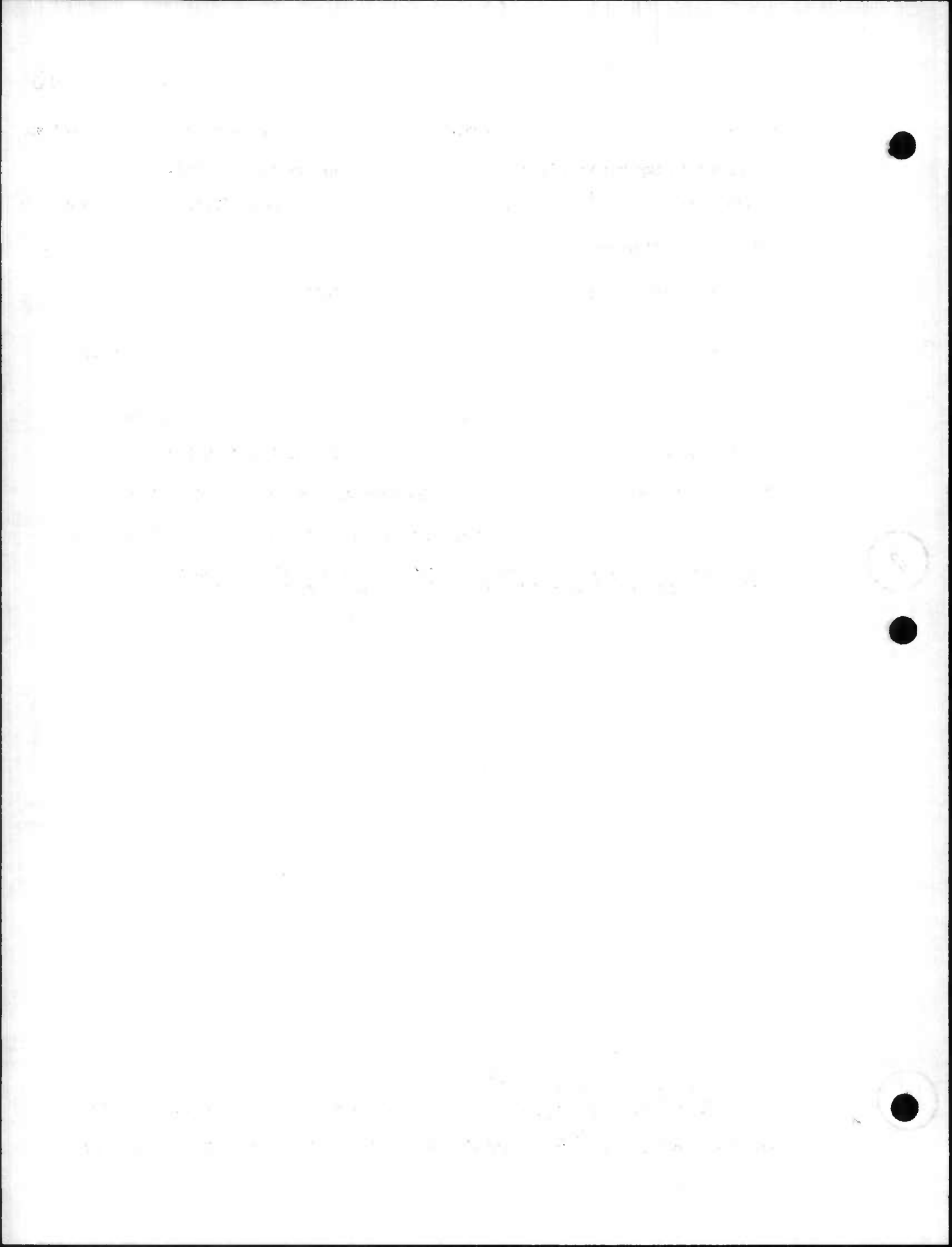
Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06744

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY HARRELSON RADCLIFFE				2. Date of Death Month Day Year MARCH 7, 1996		3. Time of Death 5:10 AM		
	4a. Facility Name (If not institution, give street and number) BON SECOURS NURSING CARE CENTER				4b. City, Town, or Location of Death ELLCOTT CITY		4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 250-22-5468		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05/30/1909	9. Birthplace (State or Foreign Country) NORTH CAROLINA	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location LANSLOWNE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 612 WASHINGTON AVENUE				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) WILLIAM C. HARRELSON				18. Mother's Name (First, Middle, Maiden Surname) MARY ELLEN CRAFT				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES E. RADCLIFFE, SR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 WASHINGTON AVE., LANSLOWNE, MARYLAND 21227				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK.		Data 3/9/96		20c. Location - City or Town, State ELKRIDGE, MARYLAND		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>Advanced Arteriosclerosis</u> Due to (or as a consequence of): b. <u>Atrial fibrillation</u> Due to (or as a consequence of): c. <u>Demantia</u> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Yrs Yrs Yrs								
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier 		29c. License number D31172		29d. Date signed (Month, Day, Year) March 7, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H.A. OKEN MD 3460 ELLCOTT CITY RD 103 ELLCOTT CITY MD 21043									
31. Date filed (Month, Day, Year) JAN 08 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Filmg, 733, item #1, 3/8/96, cyw, per fh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06745

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PRISCILLA LEE RITTMEYER				2. Date of Death Month MARCH Day 6 Year 1996		3. Time of Death 2-00 AM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL COUNTY	
Funeral Director	5. Social Security Number 235-36-7483		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 11/05/1926	
	9. Birthplace (State or Foreign Country) WEST VIRGINIA		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 201 FIRST AVENUE, MARLEY HEIGHTS		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		17. Kind of Business/Industry OWN HOME		18. Decedent's Usual Residence (Specify only highest grade completed) College (1-4 or 5+) N/A	
	19. Father's Name (First, Middle, Last) JAMES SIMMONS		20. Mother's Name (First, Middle, Maiden Surname) LIZZIE MERRITT		21. Informant's Name/Relationship (Type, Print) LOUIS J. RITTMAYER, SR.		22. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 FIRST AVE., MARLEY HEIGHTS, GLEN BURNIE, MD 21060	
	23. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		24. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		25. Date 3/9/96		26. Location - City or Town, State GLEN BURNIE, MARYLAND	
	27. Signature of Funeral Service Licensee		28. Name and Address of Facility SINGLETON FUNERAL HOME		29. 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061		30. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE	
	31. Immediate Cause (Final disease or condition resulting in death)		32. Due to (or as a consequence of):		33. Due to (or as a consequence of):		34. Due to (or as a consequence of):	
	35. Due to (or as a consequence of):		36. Due to (or as a consequence of):		37. Due to (or as a consequence of):		38. Due to (or as a consequence of):	
	39. Due to (or as a consequence of):		40. Due to (or as a consequence of):		41. Due to (or as a consequence of):		42. Due to (or as a consequence of):	
	43. Due to (or as a consequence of):		44. Due to (or as a consequence of):		45. Due to (or as a consequence of):		46. Due to (or as a consequence of):	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
	24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
	25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined				28. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Yal Shih, MD.			
	29c. License number D46962				29d. Date signed (Month, Day, Year) MARCH 6, 1996			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M. SHIRAZI, MD. HOUSE PHYSICIAN. NORTH ARUNDEL HOSPITAL. MD 21061.				31. Date filed (Month, Day, Year) MAR 08 1996			
32. Registrar's Signature Gina Davidson-Randall				33. Registrar's Signature				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06746

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES M. SEARS

2. Date of Death

FEB. 26, 1996

3. Time of Death

7:45PM

4a. Facility Name (If not institution, give street and number)

2235 REISTERSTOWN ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-32-9997

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 7, 1930

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2235 REISTERSTOWN

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurses Assistant

16b. Kind of Business/Industry

Jenkins Memorial

Hospital

17. Father's Name (First, Middle, Last)

Wallace Oakley

18. Mother's Name (First, Middle, Maiden Surname)

Nattie Lee Thompson

19a. Informant's Name/Relationship (Type, Print)

Clara Collins, Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5208 Hillwell Road Baltimore, Md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUS MEMORIAL Park

Date

3/2/96

20c. Location - City or Town, State

ARBUS, Md

21. Signature of Funeral Service Licensee

Joy Harris

22. Name and Address of Facility

CHATEAU - HARRIS Funeral Home

5240 REISTERSTOWN Rd Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CVA Possibly embolic

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM, ↓ Hearing, HTN, a-fib

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Desmangles

29c. License number

D44100

29d. Date signed (Month, Day, Year)

3/1/96

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

821 N Eutam #405, Balto, MD

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

Lili Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06747

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Mae Smith				2. DATE OF DEATH MONTH DAY YEAR March 5, 1996		3. TIME OF DEATH 7:30am	
4. SOCIAL SECURITY NUMBER 199-09-7485		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 4, 1918	
9a. FACILITY NAME (If not institution, give street and number) 1005 Fuselage Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Middle River		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 88 Transverse Ave.			
10f. ZIP CODE 21220				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY own home	
17. FATHER'S NAME (First, Middle, Last) Austin Gould				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minerva Smith			
19a. INFORMANT'S NAME (Type/Print) Douglas W. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Fuselage Ave. Baltimore Md 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 3/8/96		20c. LOCATION — City or Town, State Baltimore Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly	
22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MALIGNANT CHORDOMA OF SACRUM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Old Cerebral Hemorrhage DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D17728		29d. DATE SIGNED (Month, Day, Year) March 5, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236							
31. DATE FILED (Month, Day, Year) MAR 0 8 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06748

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ben Schaeffer				2. Date of Death Feb. 27, 1996		3. Time of Death 8:16PM								
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery								
Funeral Director	5. Social Security Number 083-01-8898		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 24, 1913								
	9. Birthplace (State or Foreign Country) New York														
Usual Residence of Decedent															
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 5501 Southwick Street				10f. Zip Code 20814		10g. Citizen of What Country? U.S.A.									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookbinder			16b. Kind of Business/Industry U.S. Government								
17. Father's Name (First, Middle, Last) Sam Shaffer				18. Mother's Name (First, Middle, Maiden Surname) Mamie Unavailable											
19a. Informant's Name/Relationship (Type, Print) Francine Berger				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Cosgrave Way, Silver Spring, Md. 20902											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Mem. Gdn.		Date 2-29-96		20c. Location - City or Town, State Olney, Maryland								
21. Signature of Funeral Service Licensee Lisa D. Williams				22. Name and Address of Facility Ives-Pearson Funeral Homes Falls Church, Va. 22046											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>a. Congestive Heart Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death 10-15-30 days</td> </tr> <tr> <td>b. Coronary Artery Disease</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Congestive Heart Failure	Approximate Interval Between Onset and Death 10-15-30 days	b. Coronary Artery Disease	c.	d.
Immediate Cause (Final disease or condition resulting in death)	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Congestive Heart Failure	Approximate Interval Between Onset and Death 10-15-30 days												
		b. Coronary Artery Disease													
		c.													
		d.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Renal Insufficiency						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) -		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Dr. Paul Kneeling MD			29c. License number D21435		29d. Date signed (Month, Day, Year) February 28, 1996							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Paul Kneeling 2101 Medical Park Dr Silver Spring Md 20902															
31. Date filed (Month, Day, Year) JAN 08 1996			32. Registrar's Signature [Signature]												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

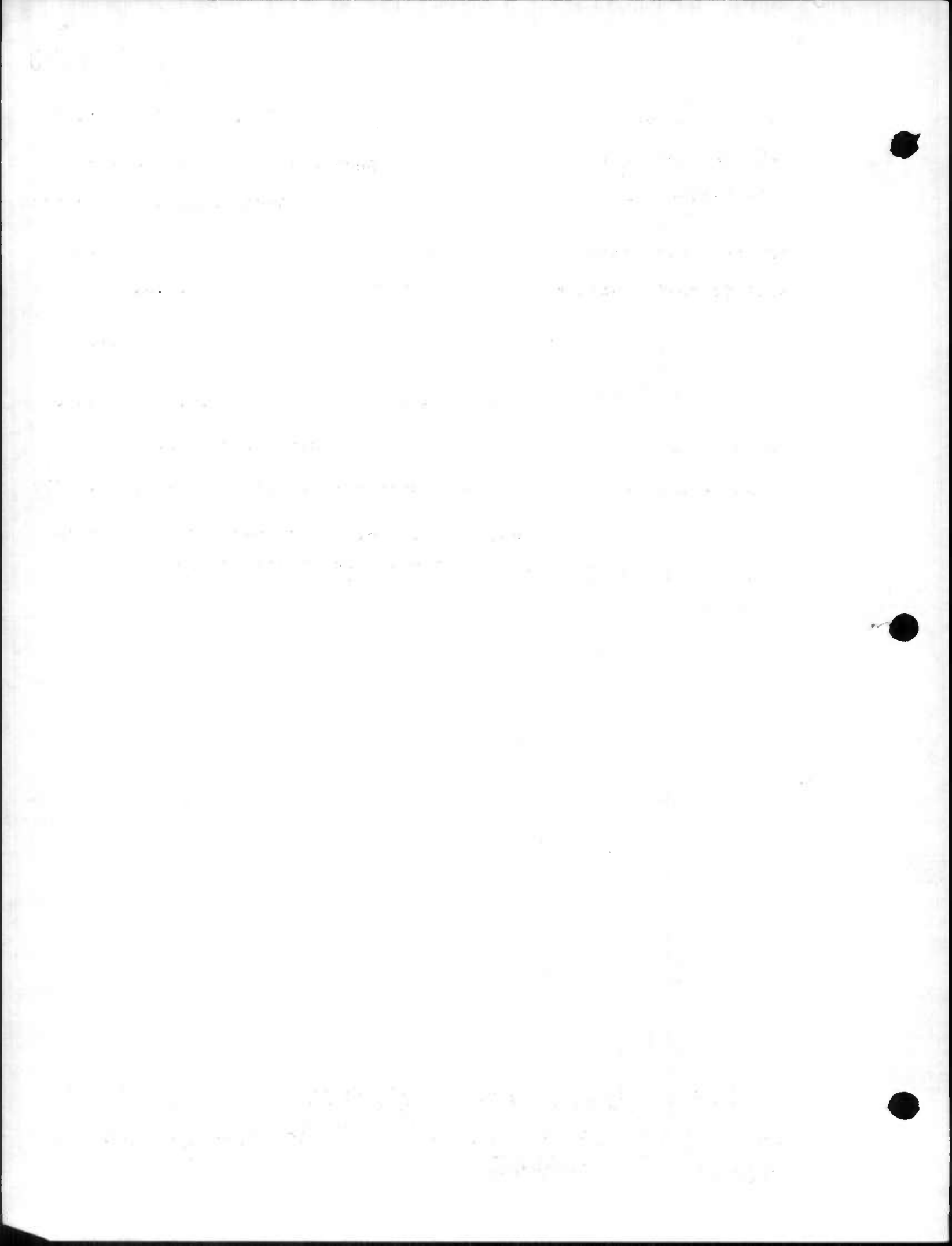
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLAUDE STEWART				2. DATE OF DEATH MONTH DAY YEAR March 4 1996		3. TIME OF DEATH 10:53 P M	
4. SOCIAL SECURITY NUMBER 220-30-2205		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 36	
9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1323 Kenton Road				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE -- American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Iron Worker		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel			
17. FATHER'S NAME (First, Middle, Last) frank stewart				18. MOTHER'S NAME (First, Middle, Maiden Surname) hilda smith			
19a. INFORMANT'S NAME (Type/Print) Lucille Stewaart				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1323 KENTON ROAD Baltimore, Md. 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 3/9/96		20c. LOCATION — City or Town, State Randallstown, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph R. Watter</i>				22. NAME AND ADDRESS OF FACILITY UNITY FUNERAL HOME 108 W. North Avenue Balto. Md. 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → sepsis DUE TO (OR AS A CONSEQUENCE OF): osteonecrosis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST rheumatoid arthritis							Approximate Interval Between Onset and Death 2 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chron's Disease, perforated colonic diverticulum							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>m. z. shu</i> M.D.				29c. LICENSE NUMBER PO 8630		29d. DATE SIGNED (Month, Day, Year) March 4, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANSUR E. SHOMALI, M.D. 22 South Greene Street Baltimore, MD 21201							
31. DATE FILED (Month, Day, Year) MAR 08 1996				32. REGISTRAR'S SIGNATURE <i>J. H. Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

24172

96 06750

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES WILLIAM SALYERS				2. DATE OF DEATH MONTH MARCH DAY 06 YEAR 1996		3. TIME OF DEATH 2:15 A.M.	
4. SOCIAL SECURITY NUMBER 213-22-1958		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH Month, Day, Year Feb. 20, 1911	
9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH Virginia	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Gambrills	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 852 Maple Road			
10f. ZIP CODE 21054				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		15b. KIND OF BUSINESS/INDUSTRY Civil Services			
17. FATHER'S NAME (First, Middle, Last) James G. C. Salyers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Gilmartin			
19a. INFORMANT'S NAME (Type/Print) James D. Salyers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 856 Maple Road, Gambrills, MD 21054			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery 3/8/96		20c. LOCATION — City or Town, State Glen Burnie, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patrick A. Arnold</i>	
22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. TONGUE CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 YEAR
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE AT MERCY					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. J. ...</i>				29c. LICENSE NUMBER D44480		29d. DATE SIGNED (Month, Day, Year) MARCH 6, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO MD 5810 Belair Rd. Balto, MD 21206							
31. DATE FILED (Month, Day, Year) MAR 08 1996		32. REGISTRAR'S SIGNATURE <i>John ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06751

Filing, 733, item #1,17,18, 3/8/96, cyw, per fh
 1 - FOR STATE REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUELLA THERESA THOMPSON				2. DATE OF DEATH MONTH DAY YEAR February 29 1996		3. TIME OF DEATH 3:00 PM	
4. SOCIAL SECURITY NUMBER 209-14-9133 A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 20, 1915	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3302 Cardenas Avenue			
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 6th grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Line Worker		16b. KIND OF BUSINESS/INDUSTRY Black & Decker	
17. FATHER'S NAME (First, Middle, Last) Warren Wertman Warren Frank Wertman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Cheryl Carrie A. Reinhardt			
19a. INFORMANT'S NAME (Type/Print) Ronald Thompson (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 Trout Farm Road, Jarrettsville, Maryland 21084			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park 3/5/96		20c. LOCATION — City or Town, State Baltimore, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → COPD DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { CHF DUE TO (OR AS A CONSEQUENCE OF): Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): Aortic Stenosis			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hemipia				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER ZAIQI WANG, M.D.				29c. LICENSE NUMBER AT2038946-BU		29d. DATE SIGNED (Month, Day, Year) 2/29/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZAIQI WANG, Union Memorial Hospital, Baltimore, MD 21208							
31. DATE FILED (Month, Day, Year) MAR 08 1996		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

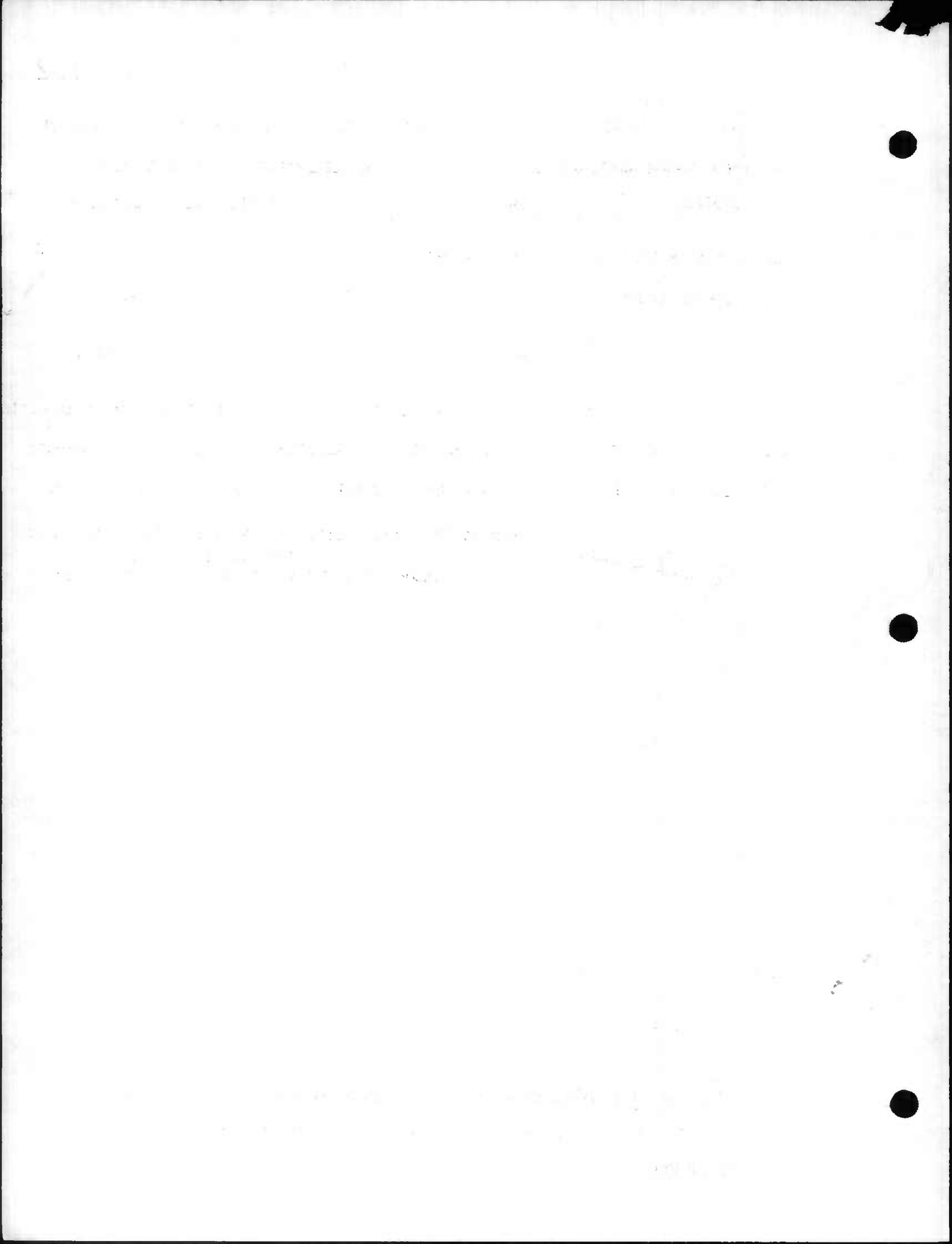
96 06752

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN GEORGE VOGEL, JR.				2. Date of Death Month Day Year MARCH 6, 1996		3. Time of Death 4:15 PM	
	4a. Facility Name (If not institution, give street and number) KNOLLWOOD MANOR NURSING HOME				4b. City, Town, or Location of Death MILLERSVILLE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 577-10-5183		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 11/15/1916	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 401 BURWOOD AVENUE		10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PIPEFITTER		16b. Kind of Business/Industry BALTIMORE GAS & ELECTRIC			
	17. Father's Name (First, Middle, Last) JOHN GEORGE VOGEL, SR.				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH M. OCHWADY			
	19a. Informant's Name/Relationship (Type, Print) MARY VIRGINIA VOGEL				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 BURWOOD AVENUE, GLEN BURNIE, MARYLAND 21061			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		20c. Location - City or Town, State 3/9/96 GLEN BURNIE, MARYLAND			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma of the Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Whitney M. Attending Doctor				29c. License number D21684		29d. Date signed (Month, Day, Year) 3-8-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C.V. CYRIAC M.D. 1600 CRAIN HWY #106 GLENBURNIE, MD 21061								
31. Date filed (Month, Day, Year) JAN 08 1996				32. Registrar's Signature Julia Davidson-Rendell				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 06753

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Daryl Winger, Jr.</i>				2. DATE OF DEATH MONTH <i>March</i> DAY <i>4</i> , YEAR <i>1996</i>		3. TIME OF DEATH <i>1:30 P.</i> M	
4. SOCIAL SECURITY NUMBER <i>219-10-3557</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 6, 1927</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Washington, D.C.</i>				9a. CITY, TOWN OR LOCATION OF DEATH <i>Towson</i>		9b. COUNTY OF DEATH <i>Baltimore</i>	
9c. FACILITY NAME (If not Institution, give street and number) <i>Manor Care Ruxton</i>							
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Perry Hall</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>9811 Richlyn Drive</i>				10f. ZIP CODE <i>21128</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12th grade</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Insurance Salesman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Insurance Company</i>	
17. FATHER'S NAME (First, Middle, Last) <i>William Daryl Winger, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Gilbert</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Margaret M. Winger (wife)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9811 Richlyn Dr., Perry Hall, MD 21128</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Mount Crematory</i>		DATE <i>3/7</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Homes, Inc.</i> <i>9705 Belair Rd., Baltimore, MD 21236</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Adenocarcinoma metastatic to vertebral</i>							
DUE TO (OR AS A CONSEQUENCE OF): <i>breaches and multiple lymph node sites</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>c. Poorly differentiated adenocarcinoma, prostate</i>							
DUE TO (OR AS A CONSEQUENCE OF): <i>5 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ischemic heart disease, pleural effusions</i>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)			
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIED BY: <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David M. Steinberg</i>				29c. LICENSE NUMBER <i>M 7542</i>		29d. DATE SIGNED (Month, Day, Year) <i>3/6/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. David Steinberg, Johns Hopkins Hospital, 600 N. Wolfe St., Balt., MD 21205</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 0 8 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06754

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD WHITE

2. Date of Death

MARCH 5, 1996

3. Time of Death

2:13 a

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

230-36-0347

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 8, 1930

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

Maryland

N/A

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1631 N. Broadway

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

John White

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Warner

19a. Informant's Name/Relationship (Type, Print)

Ms. Mildred White

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1631 N. Broadway, Balto, Md. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

3/8/96

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home

22212 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. overwhelming sepsis
Due to (or as a consequence of):

one week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. renal failure
Due to (or as a consequence of):

one week

c. alcoholic cirrhosis
Due to (or as a consequence of):

five years

d. alcohol abuse
Due to (or as a consequence of):

thirty years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gastrointestinal bleed

pericardial abscess

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sam Hung

29c. License number

M8283

29d. Date signed (Month, Day, Year)

March 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Hopkins Hospital, Baltimore, Maryland.

31. Date filed (Month, Day, Year)

MAR 0 8 1996

32. Registrar's Signature

Julia A. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Notes: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06755

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles E. Walston				2. Date of Death Month Day Year March 6, 1996				3. Time of Death 6:10 A.M.	
	4a. Facility Name (If not institution, give street and number) VA Medical Center				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 237-38-9504		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 23, 1930		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent				10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10a. Street and Number 3926 Woodridge Rd.		10f. Zip Code 21229		10g. Citizen of What Country? USA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Negro			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Worker		16b. Kind of Business/Industry Locke Insulators					
	17. Father's Name (First, Middle, Last) Anthony Walston		18. Mother's Name (First, Middle, Maiden Surname) Mary Spellman		19a. Informant's Name/Relationship (Type, Print) Mrs. Ada Walston		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3926 Woodridge Rd. Balto. Md. 21229			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadows Cemetery		20c. Location - City or Town, State 3/12/96 Newbern, N.C.					
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Locally advanced gastric cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Lauren Cobbs, M.D.		29c. License number MR 0785		29d. Date signed (Month, Day, Year) 3/7/96			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lauren Cobbs, M.D., 10 North Greene Street, Balto., MD 21201				31. Date filed (Month, Day, Year) MAR 0 8 1996		32. Registrar's Signature John D. ...			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06756

Physician
/Medical
ExaminerFuneral
Director

1. Decedant's Name (First, Middle, Last)

BELO WEISS

2. Date of Death

Month Day Year
FEBRUARY 23, 1996

3. Time of Death

10:05 a

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

075 10 1929

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 26, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedant

10a. State
Maryland10b. County
Howard10c. City, Town or Location
Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7080 Cradle Rock Way

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Date

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Letter Carrier

16b. Kind of Business/Industry

United States
Postal Service

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Unavailable

19a. Informant's Name/Relationship (Type, Print)

Garry Wiess

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7080 Cradle Rock Way, Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forrest
Veterans Cemetery

Date

2/27/96

20c. Location - City or Town, State

Reisterstown
Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes
Falls Church, Virginia 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pericardial Tamponade
Due to (or as a consequence of)

Approximate Interval Between Onset and Death

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease
Due to (or as a consequence of):

5 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D43680

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanford J. Gips, MD, Johns Hopkins Hospital, Carnegie 568, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JAN 08 1996

32. Registrar's Signature

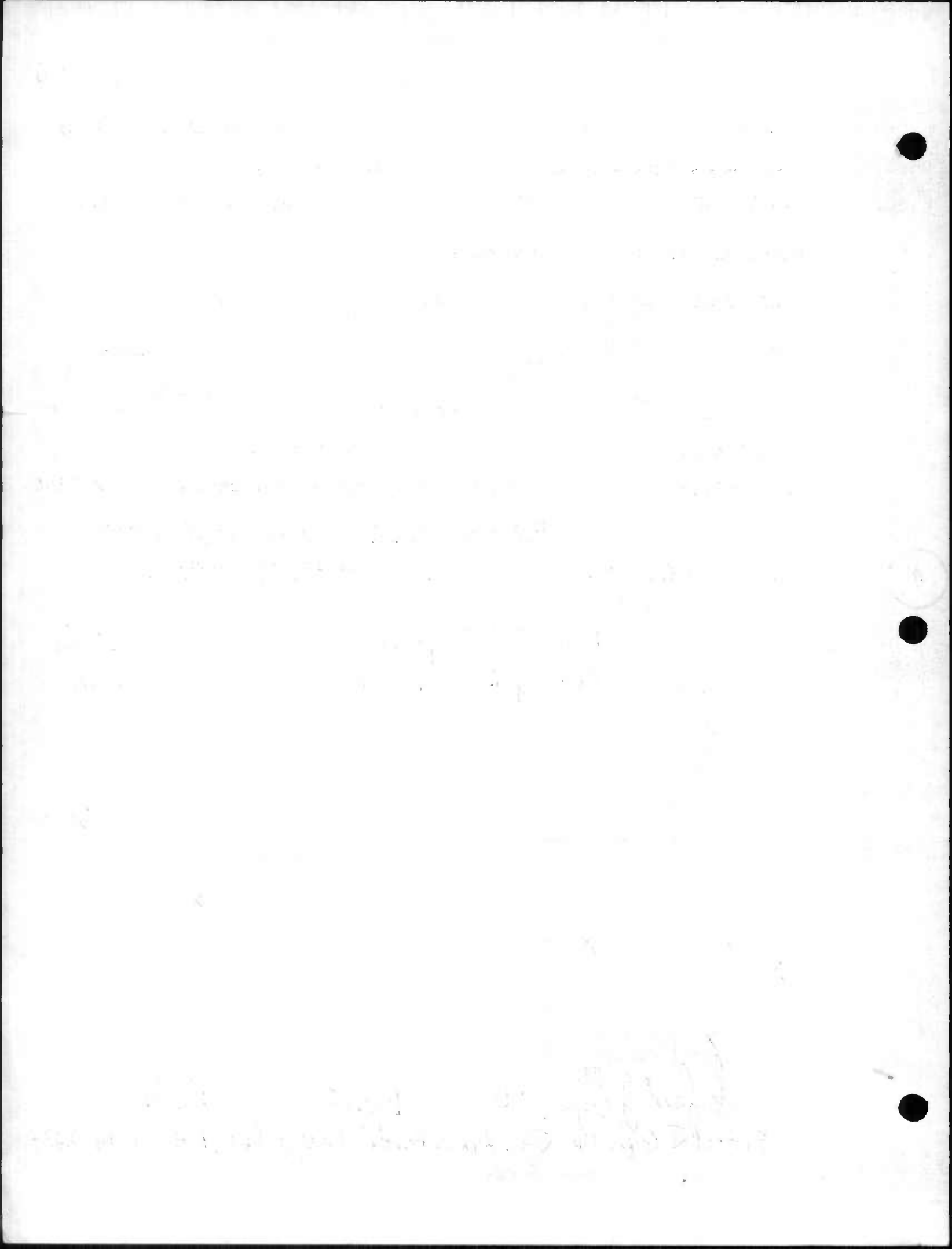
State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ticket.

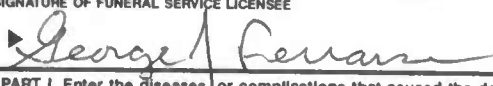


To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner



96 06757

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET HERRING ZIMMERMAN				2. DATE OF DEATH MONTH March DAY 5 YEAR 1996		3. TIME OF DEATH 9:30 A. M	
4. SOCIAL SECURITY NUMBER 213-28-4169		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 31, 1912	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 102 Croydon Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore City			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 102 Croydon Road			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Robert Quigley Herring				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Johnston			
19a. INFORMANT'S NAME (Type/Print) William Zimmerman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Croydon Road Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 3-8		20c. LOCATION — City or Town, State Timonium, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): a. Lung Cancer b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 6 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D33817		29d. DATE SIGNED (Month, Day, Year) 3/6/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Vissing, M.D. 4300 N. Charles Street Baltimore, Maryland							
31. DATE FILED (Month, Day, Year) MAR 08 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

72

Abstract 22030 SAGE

96 06758

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN JOSEPH ZAWORSKI				2. DATE OF DEATH MONTH MARCH DAY 3 YEAR 1996				3. TIME OF DEATH 10:45 PM	
4. SOCIAL SECURITY NUMBER 213-03-3793		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 28, 1908		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) RIVERVIEW NURSING CENTRE, INC.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3422 Cardenas Avenue				10f. ZIP CODE 21213			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) Fireman				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fireman			16b. KIND OF BUSINESS/INDUSTRY Local Government		
17. FATHER'S NAME (First, Middle, Last) Joseph John Zaworski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Debrahowska					
19a. INFORMANT'S NAME (Type/Print) Bertha M. Zaworski (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3422 Cardenas Avenue, Baltimore, Maryland 21213					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem. 3/7			20c. LOCATION — City or Town, State Baltimore, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Alzheimer's Disease									
DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
DUE TO (OR AS A CONSEQUENCE OF):									
DUE TO (OR AS A CONSEQUENCE OF):									
DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possible Prostate carcinoma									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D19667			29d. DATE SIGNED (Month, Day, Year) 3/4/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MICHAEL SCHWARTZ 606 HAMMONDS LANE 21225									
31. DATE FILED (Month, Day, Year) MAR 11 81996				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68766 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06759

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE D. BYRD				2. Date of Death Month 03 Day 07 Year 96		3. Time of Death 10:40 AM	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore, MD		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 250-07-2666		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Aug 22, 1922	
	9. Birthplace (State or Foreign Country) S.C.		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1036 Reverdy Road		10f. Zip Code 21212	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) NA	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Correctional officer				16b. Kind of Business/Industry Baltimore City Jail		17. Father's Name (First, Middle, Last) Angrish Byrd	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Clesia Davies				19a. Informant's Name/Relationship (Type, Print) Frances Byrd wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1036 Reverdy Road Balt, MD 21212	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Houdon Park Cem		20c. Location - City or Town, State Balt, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Sala March				22. Name and Address of Facility March F. H. West 4300 Wabash Avenue Balt, MD 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiac Arrest Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 30 min							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)			
	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Dr. Ben MD				29c. License number D 47088			
	29d. Date signed (Month, Day, Year) 3/7/96				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AMIR RON MD 645 W. Redwood, Baltimore, MD 21201			
State Registrar	31. Date filed (Month, Day, Year) MAR 11 1996				32. Registrar's Signature Ch. Shupert			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06760

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley M. Ball				2. Date of Death Month Day Year March 7 1996				3. Time of Death 1:25 pm																						
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George																						
Funeral Director	5. Social Security Number 578-14-8910		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) June 30, 18		9. Birthplace (State or Foreign Country) Virginia																						
	Usual Residence of Decedent																														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Howard		10c. City, Town or Location Laurel				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
	10e. Street and Number 9125 Grant Avenue				10f. Zip Code 20723		10g. Citizen of What Country? USA																								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unavailable College (1-4or 5+) Unavailable				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chauffeur			16b. Kind of Business/Industry Taxicab Company																							
	17. Father's Name (First, Middle, Last) Shirley Oscar Ball					18. Mother's Name (First, Middle, Maiden Surname) Mary Maria McDaniel																									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Norman L. Robinson/son-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 252 Chalet Circle, Millersville, Maryland 21108																										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 3/10/96		20c. Location - City or Town, State Dorsey, Maryland																								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Md. 20707																										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Intracranial bleed</td> <td>36 hrs.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Anticoagulation</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Intermittent Atrial fibrillation</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Diabetes Mellitus</td> <td>years</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Intracranial bleed	36 hrs.	Due to (or as a consequence of):			b.	Anticoagulation	years	Due to (or as a consequence of):			c.	Intermittent Atrial fibrillation	years	Due to (or as a consequence of):			d.	Diabetes Mellitus
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	Due to (or as a consequence of):																														
	b.	Anticoagulation	years																												
	Due to (or as a consequence of):																														
c.	Intermittent Atrial fibrillation	years																													
Due to (or as a consequence of):																															
d.	Diabetes Mellitus	years																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																							
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																															
29b. Signature and title of certifier 				29c. License number D39532		29d. Date signed (Month, Day, Year) March 8, 1996																									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy McClain 321 Prince George Street, Laurel, Maryland 20707																															
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature 																													

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

20 + 1

96 06761

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lucille C. Bigger</i>				2. DATE OF DEATH MONTH <i>Mar</i> DAY <i>6</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>5:00 a. m.</i>	
4. SOCIAL SECURITY NUMBER <i>213-09-5103</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 13, 1920</i>	
8. BIRTHPLACE (State or Foreign Country) <i>S. CAROLINA</i>				9a. FACILITY NAME (If not institution, give street and number) <i>ST. AGNES HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>	
9c. COUNTY OF DEATH <i>NA</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>N/A</i>	
10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>23 N. ABINGTON ST.</i>	
10f. ZIP CODE <i>21229</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+) <i></i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MANUFACTURING</i>				16b. KIND OF BUSINESS/INDUSTRY <i>RUBBER CO.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>UNK.</i>				18. MOTHER'S NAME (First, Middle, Maiden, Surname) <i>ANNE BLANDING</i>			
19a. INFORMANT'S NAME (Type/Print) <i>LEONARD A. BIGGER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>23 N. ABINGTON ST. BALT. MD. 21229</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <i>LEONARD PARK 3/11/96 BALTIMORE MD</i>			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY <i>GARY MARSH FUNERAL HOME P.A. 270 FREDERICK AVE BALT. MD. 21229</i>				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. due to severe anemia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> Approximate Interval Between Onset and Death <i>6 Hours</i>			
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>borderline diabetes</i>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <i></i>			
28b. TIME OF INJURY <i>M</i>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER: (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] M.D.</i>				29c. LICENSE NUMBER <i>P07532</i>			
29d. DATE SIGNED (Month, Day, Year) <i>Mar. 6, 1996</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Yelena Lipnik 900 Caton Ave, Baltimore MD 21229</i>			
31. DATE FILED (Month, Day, Year) <i>MAR 11 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

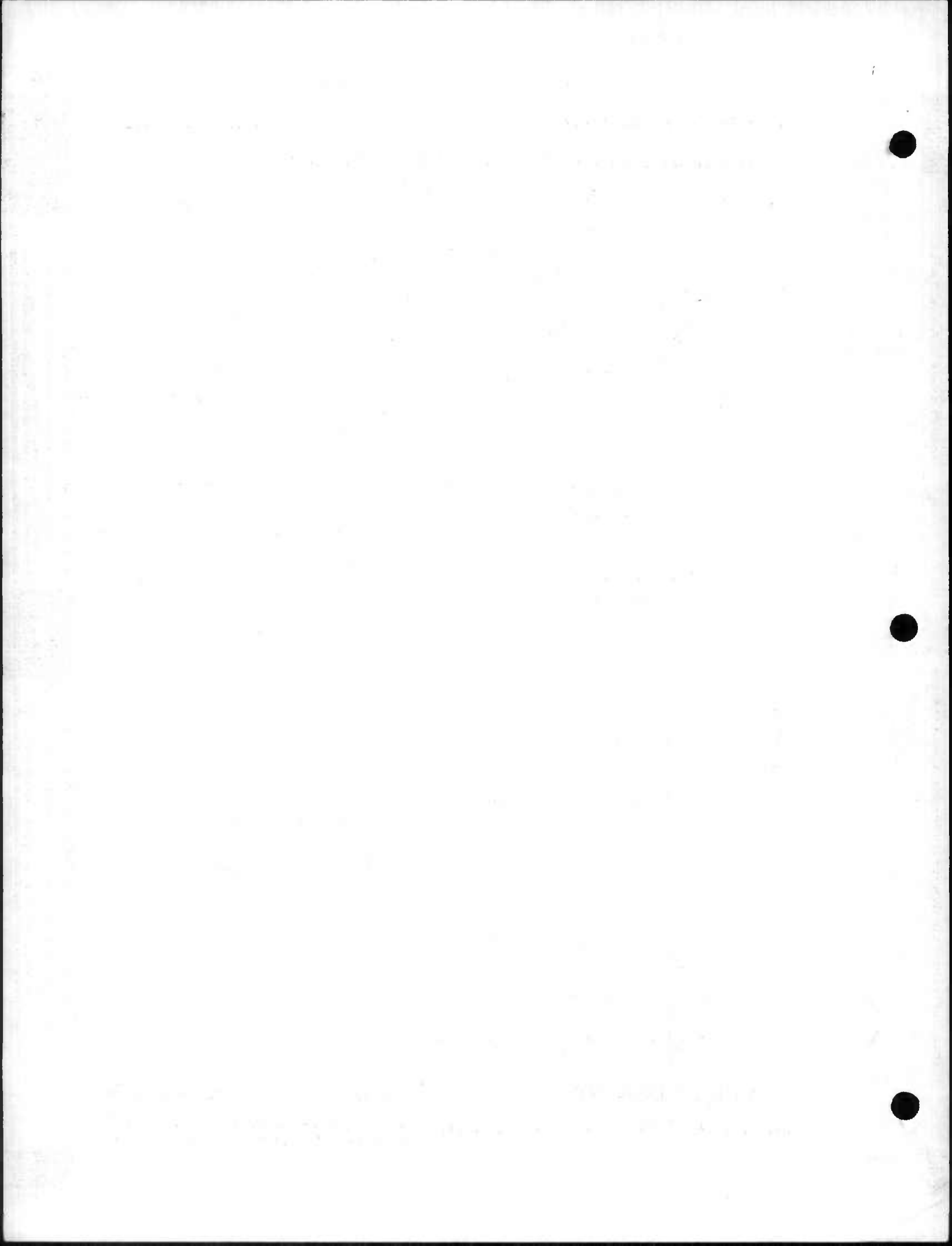
Reg. No.

96 06762

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAULINE R. BRYSON				2. Date of Death Month MARCH Day 06 Year 1996		3. Time of Death 1:50 PM											
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A											
Funeral Director	5. Social Security Number 218-66-0975		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) 09 18 53											
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE											
Usual Residence of Decedent																		
10a. State MD.			10b. County N/A			10c. City, Town or Location BALTIMORE												
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number 464 HORNEL ST.			10f. Zip Code 21224												
10g. Citizen of What Country? U.S.A.			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:												
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)												
16. Kind of Business/Industry AT HOME			17. Father's Name (First, Middle, Last) PAUL CUMBERLAND			18. Mother's Name (First, Middle, Maiden Surname) QUINTELLA SHORT												
19a. Informant's Name/Relationship (Type, Print) MARK A BRYSON, HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 464 HORNEL ST. BALTO. MD. 21224															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) OAK LAWN CEMETERY			20c. Location - City or Town, State 3-996 EASTWOOD, MD.												
21. Signature of Funeral Service Licensee Charles D. Zeller			22. Name and Address of Facility CHARLES S. ZEILENTSON INC. 6224 EASTERLY AVE. BALTO. MD.															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. hepatic failure</td> <td rowspan="4"> Due to (or as a consequence of): b. hepatitis C c. Streptococcal Sepsis d. </td> <td rowspan="4"> Approximate Interval Between Onset and Death 13 days years </td> </tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. hepatic failure	Due to (or as a consequence of): b. hepatitis C c. Streptococcal Sepsis d.	Approximate Interval Between Onset and Death 13 days years						
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. hepatic failure	Due to (or as a consequence of): b. hepatitis C c. Streptococcal Sepsis d.	Approximate Interval Between Onset and Death 13 days years															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hepatic encephalopathy, hepatorenal syndrome, oliguria, acute respiratory distress syndrome						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier Carolyn C. Houk MD			29c. License number 96008			29d. Date signed (Month, Day, Year) March 6, 1996												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CAROLYN C. HOUK MD JOHNS HOPKINS BAYVIEW MED CENTER 4940 EASTERN AVE BALTIMORE, MARYLAND 21224																		
31. Date filed (Month, Day, Year) MAR 11 1996			32. Registrar's Signature [Signature]															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

96-1243-510

State of Maryland / Department of Health and Mental Hygiene

item#4a film g733 3/11/96 ag perFH Certificate of Death

Reg. No.

96 06763

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL Robert BROCKWELL		2. Date of Death Month Day Year MARCH 7, 1996		3. Time of Death 05:52AM
	4a. Facility Name (If not institution, give street and number) 1340 BROENING HIGHWAY		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-76-4332	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) March 16, 1957
	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD.	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1340 Broening Highway		10f. Zip Code 21224		10g. Citizen of What Country? United States
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dependant		16b. Kind of Business/Industry Student
	17. Father's Name (First, Middle, Last) Ronda Wilson Brockwell		18. Mother's Name (First, Middle, Maiden Surname) Merle L. Weker		
	19a. Informant's Name/Relationship (Type, Print) Merle L. Reedy		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1340 Broening Highway Baltimore, Maryland 21224		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State 3/11/96 Baltimore, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MENTAL RETARDATION					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 					
29c. License number O.C.M.E.					
29d. Date signed (Month, Day, Year) MARCH 7, 1996					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAR 11 1996					
Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

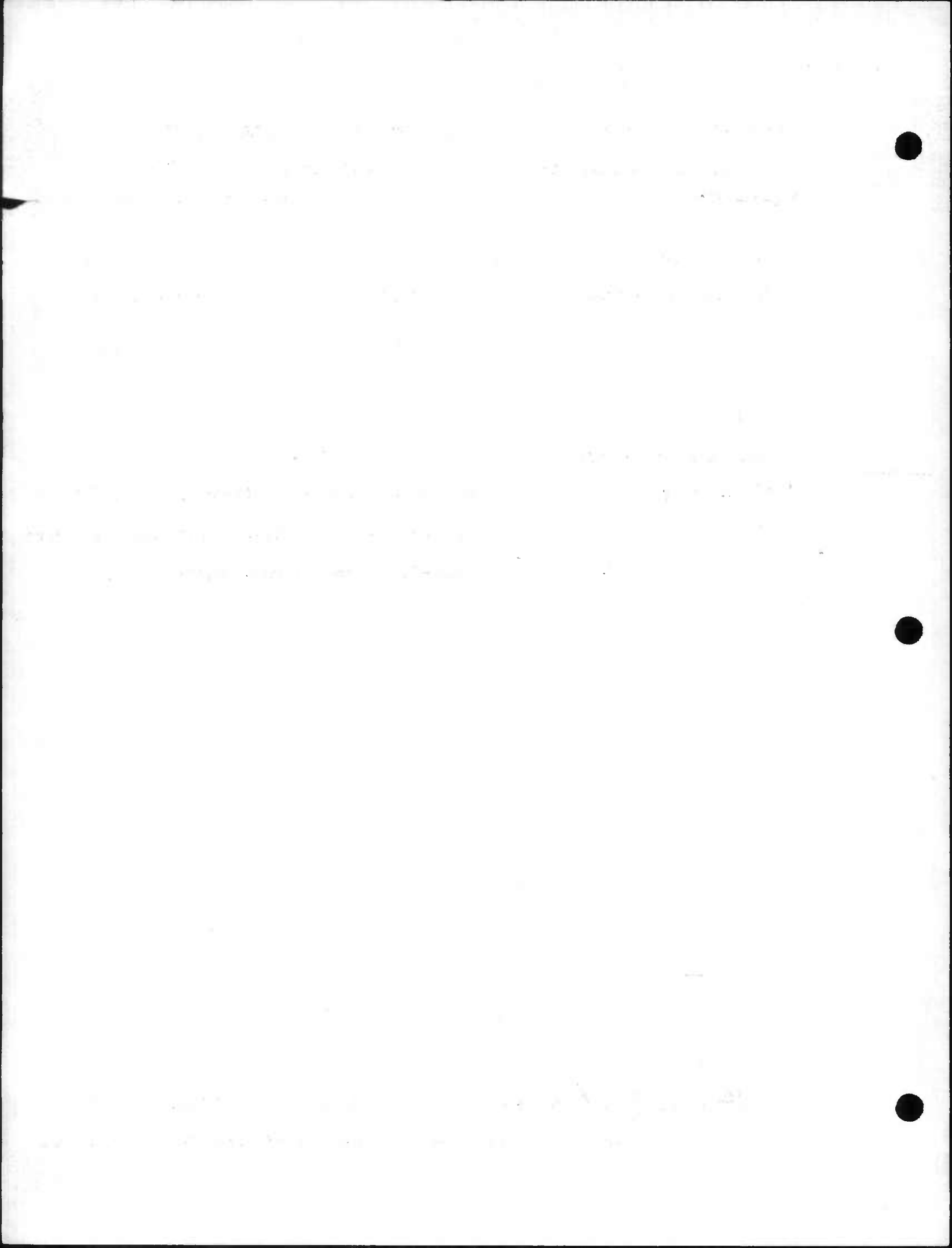
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nelson B Bootes				2. DATE OF DEATH MONTH DAY YEAR January 21 1996		3. TIME OF DEATH 9:00 P M	
4. SOCIAL SECURITY NUMBER 216-96-8327		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 16, 1922	
8. BIRTHPLACE (State or Foreign Country) unknown				9a. FACILITY NAME (If not institution, give street and number) Wicomico Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury	
9c. COUNTY OF DEATH Wicomico				10a. STATE Maryland		10b. COUNTY Wicomico	
10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P.O. Box 2378	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) (niece) Sharon Rhodes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) In State rem.				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Dir.				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm.B026-Baltimore, Maryland 21201-1559			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Coronary Artery Disease c. Arteriosclerosis							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder CVA - Several							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D02026		29d. DATE SIGNED (Month, Day, Year) JAN 22 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) F.G. Arthes, MD 1622 A Ocean Pines, Berlin, Md. 21811							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06765

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Marie Bearer

2. Date of Death

March 6, 1996

3. Time of Death

0100 hr

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3739 Courtleigh Drive

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

220-22-3112

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 15, 1912

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rockdale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8335 Mindale Circle Apt. D

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 Year College

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Medical Secretary

16b. Kind of Business/Industry

Physician's Office

17. Father's Name (First, Middle, Last)

Edward J. Levie

18. Mother's Name (First, Middle, Maiden Surname)

Leonie Morrel

19a. Informant's Name/Relationship (Type, Print)

Mr. Leo R. Levie (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6008 Shady Spring Avenue Baltimore, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

3/9/96

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter if a disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Squamous CA of the Right Lower Port of Cervical Esophagus 2 1/2 in. to Neck & 7 B in

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia of Alzheimer type
Old Depression w/ Comp. RABBB LAK
Essential Hypertension 2
Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. J. NO

29c. License number

D15217

29d. Date signed (Month, Day, Year)

3/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.C. GALVOZ MD. 5400 Old Court Rd. Randallstown MD 21133

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

John D. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

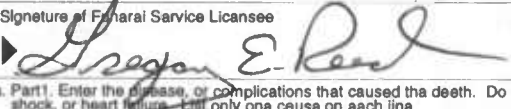

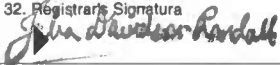
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06766

item#1 film g733 3/11/96 ag perFH Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAURICE STANLEY BLACKBURN JR.					2. Date of Death Month MARCH Day 6 , Year 1996		3. Time of Death 11:53 AM																
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL					4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A																
Funeral Director	5. Social Security Number 224-20-7429		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 11, 1925		9. Birthplace (State or Foreign Country) Maryland															
	Usual Residence of Decedent																							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
10e. Street and Number 3405 Yardley Drive				10f. Zip Code 21222		10g. Citizen of What Country? United States																		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Millwright		16b. Kind of Business/Industry Steel Industry																		
17. Father's Name (First, Middle, Last) Maurice Stanley Blackburn					18. Mother's Name (First, Middle, Maiden Surname) Marie Deterer																			
19a. Informant's Name/Relationship (Type, Print) Mrs. Jean Louise Blackburn					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Yardley Drive Dundalk, Maryland 21222																			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery 3/9/1996			20c. Location - City or Town, State Baltimore, Maryland																		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>MITRAL VALVE INSUFFICIENCY</td> <td>3 DAYS</td> </tr> <tr> <td>b.</td> <td>PAPILLARY MUSCLE RUPTURE</td> <td>3 DAYS</td> </tr> <tr> <td>c.</td> <td>MYOCARDIAL INFARCTION</td> <td>11 DAYS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	MITRAL VALVE INSUFFICIENCY	3 DAYS	b.	PAPILLARY MUSCLE RUPTURE	3 DAYS	c.	MYOCARDIAL INFARCTION	11 DAYS	d.			Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	MITRAL VALVE INSUFFICIENCY	3 DAYS																					
	b.	PAPILLARY MUSCLE RUPTURE	3 DAYS																					
	c.	MYOCARDIAL INFARCTION	11 DAYS																					
	d.																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE PERIPHERAL VASCULAR DISEASE TOBACCO USE								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number M5246		29d. Date signed (Month, Day, Year) March 6, 1996																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEPHEN V. JACKMAN, M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.																								
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature 																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

item#16a&16B file# g733 3/11/96 ag perFH

Certificate of Death

Reg. No.

96 06767

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stella D. Bonkowski				2. Date of Death Month Day Year March 4, 1996		3. Time of Death 8:55pm	
	4a. Facility Name (If not institution, give street and number) Good Samaritan				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-01-3303		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) 12/09/1912	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A		10e. Street and Number 2219 Portugal Street			10f. Zip Code 21231	
	10g. Citizen of What Country? USA			11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer/Factory LABORER			16b. Kind of Business/Industry FACTORY Hellers Mattress Co.			17. Father's Name (First, Middle, Last) Gregory Bonkowski	
	18. Mother's Name (First, Middle, Maiden Surname) Louise Grungick			19a. Informant's Name/Relationship (Type, Print) Shirley A. Eckloff Niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Hopewell Ave. Baltimore, Maryland 21221	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		Date 3/8		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee <i>David J. Weber</i> CFSP		22. Name and Address of Facility David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md 21231					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bacterial Sepsis Due to (or as a consequence of): Aspiration pneumonia Due to (or as a consequence of): Dementia Alzheimer's type Due to (or as a consequence of): Approximate Interval Between Onset and Death 4 wks. 1 wk > 2 yrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier <i>M. N. Khan MD</i>		29c. License number D25391		29d. Date signed (Month, Day, Year) 3-6-96			
State Registrar	30. Name and address of person who completed cause of death (item 23a) (Type, Print) 5601 - Loch Raven Blvd Baltimore MD 21239							
	31. Date filed (Month, Day, Year) MAR 1 1996		32. Registrar's Signature <i>John D. ...</i>					

96 06768

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAWRENCE BOOTS JR.				2. DATE OF DEATH MONTH DAY YEAR February 27 1996		3. TIME OF DEATH 635 P M	
4. SOCIAL SECURITY NUMBER 217-64-5853		5. SEX M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1962	
8a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1816 W. LANVALE STREET				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) 2YRS				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONCIERGE		16b. KIND OF BUSINESS/INDUSTRY OMNI HOTEL	
17. FATHER'S NAME (First, Middle, Last) LAWRENCE S. BOOTS SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) BARBARA D. WILSON			
19a. INFORMANT'S NAME (Type/Print) LAWRENCE S. BOOTS SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3433 EDMONDSON AVE., BALTIMORE, MD. 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY 3-2-96		20c. LOCATION — City or Town, State BALTIMORE, MD.		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepatic Failure DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sepsis DUE TO (OR AS A CONSEQUENCE OF): Acquired Immunodeficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Hypertension Cryoglobulinemia DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christina M. Fisher MD</i>				29c. LICENSE NUMBER D39698		29d. DATE SIGNED (Month, Day, Year) 2/27/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christina M. Fisher 22 S. Greene St. Baltimore, MD 21201							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06769

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) YVONDA BOYD				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 29, 1996		3. TIME OF DEATH 3:30 A M	
4. SOCIAL SECURITY NUMBER 215-74-7651		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 22, 1959	
9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPICE (STELLA MARIS)				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 586 YALE AVENUE			
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY FACTORY	
17. FATHER'S NAME (First, Middle, Last) CHRISTOPHER BOYD				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE BRYANT			
19a. INFORMANT'S NAME (Type/Print) GREGORY K. JEFFERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 NORTH BROOKFIELD, BALTIMORE, MD. 21217			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. LOCATION — City or Town, State 3-6-96 BALTIMORE, MD.		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF): HIV INFECTION							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
24. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) HOSPICE							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D40480		29d. DATE SIGNED (Month, Day, Year) 2/29/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO, MD 5710 BELAIR RD. BALTO., MD 21206							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06770

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT

C.

BIDGOOD

2. Date of Death

Month

Day

Year

MARCH

6,

1996

3. Time of Death

02:30 PM

4a. Facility Name (If not Institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-01-8451

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

March 23, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

719 Maiden Choice Lane # 139

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administration

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Macon C. Bidgood

18. Mother's Name (First, Middle, Maiden Surname)

Annie G. Bidgood

19a. Informant's Name/Relationship (Type, Print)

George V. Bidgood, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Trueman Court Baltimore, Maryland 21244

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial

Date

3/9/96

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring RoadArbutus
21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

20 YEARS

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

20 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

N2563

29d. Date signed (Month, Day, Year)

MARCH 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK HU, 600 N. WOLFE STREET, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

96 06771

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul William Bauer				2. DATE OF DEATH MONTH MAR DAY 9 YEAR 96		3. TIME OF DEATH 0501 M	
4. SOCIAL SECURITY NUMBER 217-92-7021		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 20 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 6 76	
8. FACILITY NAME (If not institution, give street and number) 6463 Cedar Furnace Cir				9b. CITY, TOWN OR LOCATION OF DEATH Glenn Burnie		9c. COUNTY OF DEATH AA	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lansdowne		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 2611 First Avenue				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) welder		16b. KIND OF BUSINESS/INDUSTRY construction			
17. FATHER'S NAME (First, Middle, Last) Daniel J. Bauer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Deborah A. Bauer			
19a. INFORMANT'S NAME (Type/Print) Daniel J. Bauer, father				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2611 First Avenue Lansdowne, Maryland 21227			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State 3/11/96 Catonsville, MD.		22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Shotgun Wound Head							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 7 Homicide		28a. DATE OF INJURY (Month, Day, Year) 3/9/96		28b. TIME OF INJURY 0452 M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURED Shot Self		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) Friend's Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Glenn Burnie, MD.			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i>				29c. LICENSE NUMBER D06054		29d. DATE SIGNED (Month, Day, Year) 3/9/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America 21035							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06772

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARVEY CARRINGTON				2. Date of Death Month Day Year MARCH 7, 1996				3. Time of Death 6:09 P	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A	
Funeral Director	5. Social Security Number 229-14-8301		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 27, 1908		9. Birthplace (State or Foreign Country) N. Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1110 KEVIN ROAD				10f. Zip Code 21229		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide			16b. Kind of Business/Industry Hospital		
	17. Father's Name (First, Middle, Last) William Carrington				18. Mother's Name (First, Middle, Maiden Surname) Martha Beard					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles Carrington/grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 E. Hoffman Street, Balto., MD. 21213					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 3/13		20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>				22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE BALTO. 21207					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Ventricular tachycardia</i> Due to (or as a consequence of): b. <i>Hypotension</i> Due to (or as a consequence of): c. <i>Renal failure</i> Due to (or as a consequence of): d. <i>Severe Pulmonary Hypertension</i>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Ngoc-Ha Nguyen, MD</i>				29c. License number L8085		29d. Date signed (Month, Day, Year) 3/7/96				
30. Name and address of person who completed cause of death (item 23a) (Type, Print) 600 N. WOLFE ST. BALTIMORE, MD 21205										
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature <i>Jabin [Signature]</i>								

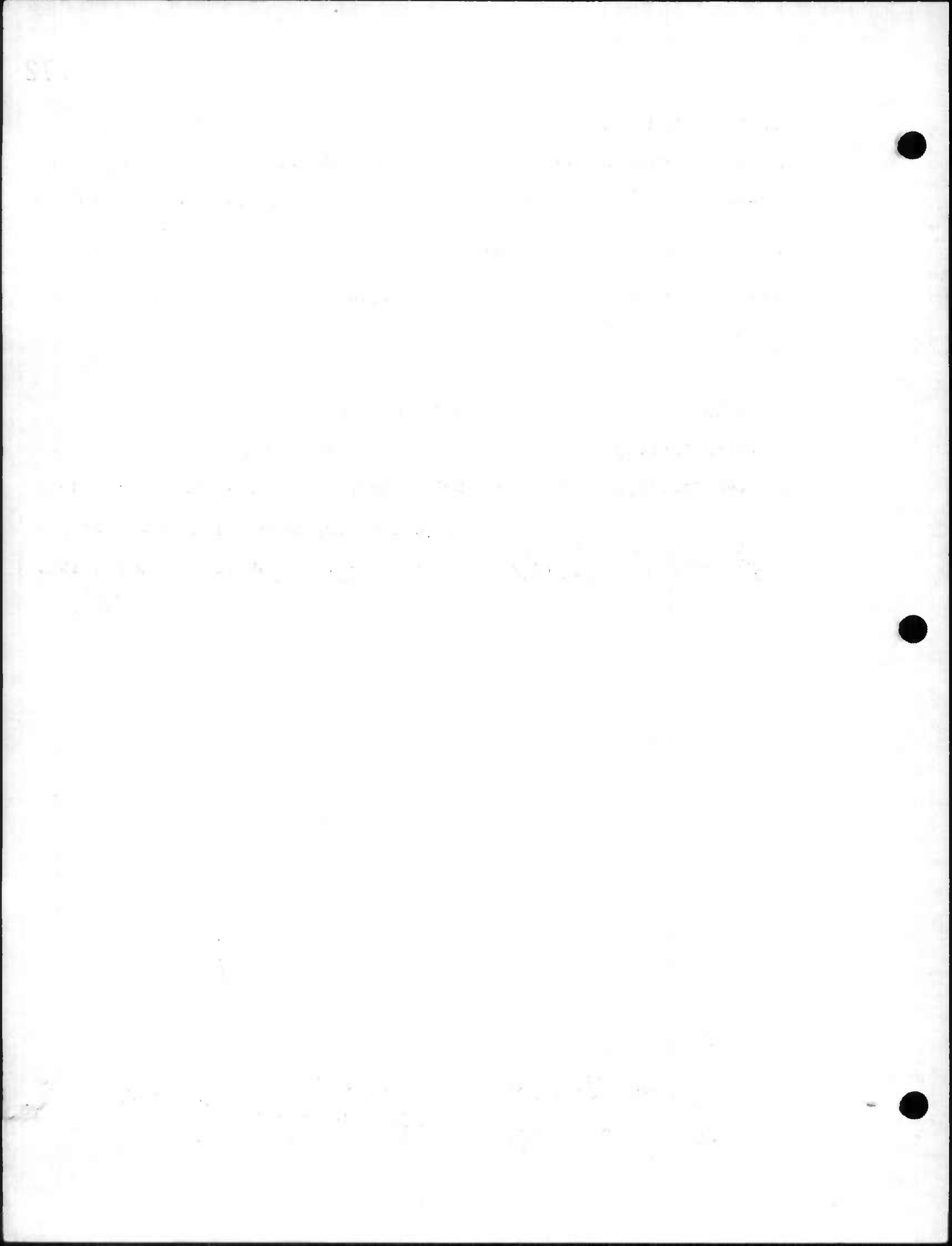
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 27, PER MEO FILM G-733
3/11/96 t.t

State of Maryland / Department of Health and Mental Hygiene

96 06773

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OLGA CAMACHO						2. Date of Death Month Day Year MARCH 9, 1996		3. Time of Death 1:48 P	
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL						4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N.A.	
Funeral Director	5. Social Security Number N.A.		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) 11-6-36		9. Birthplace (State or Foreign Country) Costa Rica	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State San Jose		10b. County N.A.		10c. City, Town or Location San Jose				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number P.O. Box 4211-1000				10f. Zip Code 1000		10g. Citizen of What Country? Costa Rica			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Spanish Costa Rican			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+) _____				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In own home		
	17. Father's Name (First, Middle, Last) Juan Camacho						18. Mother's Name (First, Middle, Maiden Surname) Olga Corrales			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Danilo Alfaro (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 4211-1000 San Jose, Costa Rica					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Burial				20b. Place of Disposition (Name of cemetery, crematory or other place) Jardines del Recuerdo		Date 3/13/96		20c. Location - City or Town, State San Jose, Costa Rica	
	21. Signature of Funeral Service Licensee <i>Joseph N. Zannino Jr.</i>				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling St. Baltimore, Md. 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury N/A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number M5171		29d. Date signed (Month, Day, Year) 3/9/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zbigniew Paul Chowaniec Johns Hopkins Hospital										
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06774

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen Joseph

CHES, Jr.

2. Date of Death
Month Day Year

March 7, 1996

3. Time of Death

5:26 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

216-20-1356

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 15, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7942 Wynbrook Road

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Balto. City Police Detective

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

Stephen Joseph Ches, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marie Victoria Mieswjoska

19a. Informant's Name/Relationship (Type, Print)

Catherine J. Ches

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7942 Wynbrook Road Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus Cem. 3/11/96 Baltimore, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

End Stage Ischemic Heart disease

Due to (or as a consequence of):

b.

Congestive cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 yr

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, End stage renal disease.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending

29c. License number

D16444

29d. Date signed (Month, Day, Year)

March 7th 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. S. NAIR M.D 2112 Belair Road. Fallston - MD 21047

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part contains a detailed analysis of the economic situation.

3. The third part deals with the social and cultural aspects of the situation.

4. The fourth part discusses the political situation and the role of the government.

5. The fifth part contains conclusions and recommendations for the future.

6. The sixth part is a summary of the main findings of the report.

7. The seventh part contains a list of references and sources.

8. The eighth part is a list of appendices and supplementary material.

9. The ninth part contains a list of tables and figures.

10

11. The tenth part contains a list of abbreviations and symbols.

12. The eleventh part is a list of footnotes and references.

13

96 06775

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth Chapple				2. DATE OF DEATH MONTH DAY YEAR March 5 1996		3. TIME OF DEATH 9:05 A M	
4. SOCIAL SECURITY NUMBER 215-28-5814		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 6 1909	
8. BIRTHPLACE (State or Foreign Country) Michigan				9a. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH Ruxton	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2 Smeton Pl.	
10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Charles W. Chapple				18. MOTHER'S NAME (First, Middle, Maiden Surname) Betsy H. Sampson			
19a. INFORMANT'S NAME (Type/Print) Doris Reichard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15121 Glade Dr. 1E Silver Spring Md. 20906			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Hilltop Service Corp. 3-9-96		20c. LOCATION — City or Town, State Towson, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson F.H. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COPD, end stage DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							NA
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D18822		29d. DATE SIGNED (Month, Day, Year) 3/6/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HABERSAT 214 Mt Carmel Rd, Parkton, MD 21120							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06776

item#26 film g733 3/11/96 ag per HOSP.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JOHN F COZAD

2. Date of Death

March 5, 1996

3. Time of Death

8:07 A.M.

4a. Facility Name (If not Institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

217-38-8511

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 18, 1940

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2137 Nodleigh Terrace

10f. Zip Code

21084

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore County
Schools

17. Father's Name (First, Middle, Last)

John L Cozad

18. Mother's Name (First, Middle, Maiden Surname)

Helen E Sluss

19a. Informant's Name/Relationship (Type, Print)

Mrs. Carolyn L. Cozad

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2137 Nodleigh Terrace Jarrettsville, Md. 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Memorial

Date

3/8/96

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. CARDIAC
Cardiopulmonary Arrest; Arrhythmia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Immediate

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. CARDIOMYOPATHY / RENE FAUCIE

Due to (or as a consequence of):

Years

c. Hypertension / Diabetes

Due to (or as a consequence of):

Years

d. Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0033163

29d. Date signed (Month, Day, Year)

March 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARLA JANSON M.D.

Fallston General Hospital

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

Julia Dawson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3.

1. The first part of the document is a letter from the Secretary of the State to the President, dated 18th March 1861. It contains a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

2. The second part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

3. The third part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

4. The fourth part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

5. The fifth part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

6. The sixth part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

7. The seventh part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

8. The eighth part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

9. The ninth part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

10. The tenth part of the document is a report on the progress of the work of the State during the past year, and a statement of the financial condition of the State.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06777

ITEM#10F film g733 3/13/96 ag perFH Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clay, Charles A		2. Date of Death Month March Day 4th Year 1996		3. Time of Death 12:42 AM
	4a. Facility Name (Not Institution, give street and number) Siani Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 212-28-2808	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	8. Date of Birth (Month, Day, Year) APRIL 4, 1930	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10a. Street and Number 4003 W. GARRISON AVENUE		10f. Zip Code 21215		10g. Citizen of What Country? USA.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th GRADE College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry DISTILLERY
	17. Father's Name (First, Middle, Last) DAVID CLAY		18. Mother's Name (First, Middle, Maiden Surname) LILLIAN LANE		
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLENE ALSTON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4003 W. GARRISON AVE., BALTIMORE, MD.		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 3-9-96 BALTIMORE, MD.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223		
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. U-tach arrest Due to (or as a consequence of): b. anemia Due to (or as a consequence of): c. weakness LCF Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Christe Hetzel MD		29c. License number A5240231CH9922		29d. Date signed (Month, Day, Year) March 4, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christe Hetzel MD Siani Hospital					
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature Jahia Anderson-Randall			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS DANIEL CREECH				2. DATE OF DEATH MONTH DAY YEAR February 24, 1996		3. TIME OF DEATH 6:15 a.	
4. SOCIAL SECURITY NUMBER 242-50-8847		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 9, 1929	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) 47 Ridge Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Edgewater	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Edgewater				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 47 Ridge Avenue	
10f. ZIP CODE 21037				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1946-1966				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook				16b. KIND OF BUSINESS/INDUSTRY Military			
17. FATHER'S NAME (First, Middle, Last) Levi Melton Creech				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Mae Witcher			
19a. INFORMANT'S NAME (Type/Print) Edna Creech				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Ridge Avenue-Edgewater, Maryland 21037			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade, dir.</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic obstructive lung disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert T. Peterson</i>				29c. LICENSE NUMBER D24804		29d. DATE SIGNED (Month, Day, Year) 2-26-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert T. Peterson 600 Ridgely Ave Annapolis Md							
31. DATE FILED (Month, Day, Year) MAR 11 1996							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06779

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Regina Marie Carter				2. Date of Death Month March Day 8 Year 96		3. Time of Death 8:45AM	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-09-4545		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 4, 1922	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore County		10c. City, Town or Location Perry Hall	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4338 Penn Avenue		10f. Zip Code 21236		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk		16b. Kind of Business/Industry Drug Store		17. Father's Name (First, Middle, Last) John Unknown		
18. Mother's Name (First, Middle, Maiden Surname) Theresa Unknown Dearing		19a. Informant's Name/Relationship (Type, Print) Howard Alfred Carter, Jr./Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 3355, Johnstown, Pennsylvania 15904		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Date 3/12/96		20d. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee Kathleen M. Murphy		
22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Colonic Ca		Approximate interval Between Onset and Death 1 year		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
23c. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Colonic Ca		23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number P-07619		
29d. Date signed (Month, Day, Year) March - 08 - 96		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ali Saifi, Good Samaritan Hospital, 5601 Loch Raven Blvd, Baltimore, MD 21233		31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1



OK

96 06780

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Mary Margaret Donahue</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>9</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>8:10 AM</u>	
4. SOCIAL SECURITY NUMBER <u>212-01-4580</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>7-23-13</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>Md.</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Catonsville</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>303 Maiden Choice Lane</u>				10f. ZIP CODE <u>21228</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Grade 12</u> College (1-4 or 5+) <u>Secretary</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <u>Secretary</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Dixie Steel</u>			
17. FATHER'S NAME (First, Middle, Last) <u>James P. Donohue</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary M. Wedekind</u>			
19a. INFORMANT'S NAME (Type/Print) <u>James Joseph Donohue</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1504 Summit Ave. - Catonsville, Md. 21228</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>New Cathedral Cemetery 3-12-96 Balto., Md.</u>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>G. Truman Schwab</u>				22. NAME AND ADDRESS OF FACILITY <u>5151 Baltimore National Pike Baltimore, Md. 21229</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>anaplastic thyroid carcinoma with local invasion and brain metastases.</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Kris E. Kuhn, M.D.</u>				29c. LICENSE NUMBER <u>D37464</u>		29d. DATE SIGNED (Month, Day, Year) <u>March 9, 1996</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>KRIS E. KUHN, M.D. 3320 Benson Avenue Baltimore, MD 21227</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 11 1996</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

per FR State of Maryland / Department of Health and Mental Hygiene
item#4a&7 film g733 3/11/96 ag Certificate of Death

96 06781

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE D. DAVIS Jr.				2. Date of Death Month Day Year MARCH 06, 1996		3. Time of Death 0505 AM											
	4a. Facility Name (If not institution, give street and number) 12 bell adonna court 12 BELLADONNA CT.				4b. City, Town, or Location of Death Owings Mills		4c. County of Death BALTIMORE											
Funeral Director	5. Social Security Number 219-72-6792		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1956 July 15, 1966	9. Birthplace (State or Foreign Country) Maryland										
	Usual Residence of Decedent																	
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Owings Mills			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number 12 Belladonna Court				10f. Zip Code 21117		10g. Citizen of What Country? United States of America												
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tow truck driver			16b. Kind of Business/Industry Davis Towing											
17. Father's Name (First, Middle, Last) Dewey Davis				18. Mother's Name (First, Middle, Maiden Surname) Virginia Alfred														
19a. Informant's Name/Relationship (Type, Print) Virginia Davis (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Smith Ave. Baltimore, 21209														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 3/9/96		20c. Location - City or Town, State Pikesville, MD											
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, MD 21133														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of):</td> <td rowspan="4"></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of):		b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of):																
	b.	Due to (or as a consequence of):																
	c.	Due to (or as a consequence of):																
	d.	Due to (or as a consequence of):																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) 3-6-96		28b. Time of Injury UNKNOWN M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
			28d. Describe how Injury occurred UNKNOWN			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME												
			28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 BELLADONNA CT. BALTIMORE CO., MD.															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner			1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier			29c. License number O.C.M.E			29d. Date signed (Month, Day, Year) MARCH 06, 1996												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. LAFON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201																		
31. Date filed (Month, Day, Year) MAR 11 1996			32. Registrar's Signature John A. ...															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06782

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE DOUGLAS				2. DATE OF DEATH MONTH MARCH DAY 1 YEAR 1996		3. TIME OF DEATH 7:40 P.M.	
4. SOCIAL SECURITY NUMBER 216-32-1310		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 12, 1934	
8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA		9a. FACILITY NAME (If not institution, give street and number) STELLA MARIS (MERCY HOSPITAL)		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1010 WEST BALTIMORE STREET			
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th GRADE College (1-4 or 5+) HOMEMAKER		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) LEROY STEVENSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALMA WILLIAMS			
19a. INFORMANT'S NAME (Type/Print) LIZA HUGHES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 FEATHERBED LANE, BALTIMORE, MD. 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		DATE 3-7-96		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Non-small Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death MOS.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE AT MERCY					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D40480		29d. DATE SIGNED (Month, Day, Year) March 4, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO, MD 5810 BELAIR RD BARTO, MD 21206							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06783

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRETALION

EDWARDS

2. Date of Death

Month
FEBDay
23Year
1996

3. Time of Death

6.00 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Pikesville N/H

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

Pikesville

5. Social Security Number

219-22-5141

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 8, 1914

9. Birthplace (State or Foreign Country)

S. C.

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6307 Western Run Drive

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th gradeCollege (14 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Baltimore City Schools

17. Father's Name (First, Middle, Last)

Alva J. White

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Steele

19a. Informant's Name/Relationship (Type, Print)

Eurphan McLaughlin Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Run
6307 Western Drive Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Md Nat Memorial Park

Date

2/27/96

20c. Location - City or Town, State

Laurel, Md

21. Signature of Funeral Service Licensee

Jala March

22. Name and Address of Facility

MARCH F/H-WEST 4300 WABASH AVE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cerebral Thrombosis
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Requiring Diabetes Mellitus

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Deborah Irene Pierce

29c. License number

D45931

29d. Date signed (Month, Day, Year)

Feb 26, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Pierce 7220 Park Heights Ave. Balt. Md 21208

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

John H. H. H.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06784

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THADDEUS DONNELL ERVIN

2. Date of Death

Month Day Year
MARCH 06, 1996

3. Time of Death

4:43 AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

N/A

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 28, 1996

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3118 Ravenwood Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dependent

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

John Frank Ervin

18. Mother's Name (First, Middle, Maiden Surname)

Tonya LaRicci

19a. Informant's Name/Relationship (Type, Print)

Tonya LaRicci / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3118 Ravenwood Avenue Baltimore, Md. 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hilltop Service Corporation

Date

3/9/96

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee Mark T. Zavoyna

Mark T. Zavoyna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Md. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Severe Bleeding
Due to (or as a consequence of)Approximate
Interval Between
Onset and Death

36 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Spontaneous Rupture of Liver Hematoma
Due to (or as a consequence of)

36 hours

c. Necrotizing Enterocolitis
Due to (or as a consequence of)

36 hours

d. Prematurity, 27 weeks gestation
Due to (or as a consequence of)

6 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Probable Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mantel C. Allen MD

29c. License number

D26728

29d. Date signed (Month, Day, Year)

March 6, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mantel C. Allen MD The Johns Hopkins Hospital, 600 N. Wolfe St. Baltimore, MD

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

John D. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06785

FOR 6/9/97 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1 - STATE REGISTRAR Item: 17 per Informant G-748 CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PAUL JOSEPH ENSOR				2. DATE OF DEATH MONTH DAY YEAR March 6, 1996		3. TIME OF DEATH 10:30 PM	
4. SOCIAL SECURITY NUMBER 218-28-0681		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 20, 1931	
8. BIRTHPLACE (State or Foreign Country) Md.		9a. FACILITY NAME (If not institution, give street and number) 105 Charmuth Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Lutherville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lutherville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 105 Charmuth Rd.				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Security Officer		16b. KIND OF BUSINESS/INDUSTRY Balt. County Sheriffs Dept.			
17. FATHER'S NAME (First, Middle, Last) Wilton L. Ensor, Jr. Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice M. Magness			
19a. INFORMANT'S NAME (Type/Print) Mrs. Charlotte L. Ensor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Charmuth Rd. Lutherville, Md. 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns. 3/11/96 Timonium, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Esophageal Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29a. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Celano MD				29c. LICENSE NUMBER D38929		29d. DATE SIGNED (Month, Day, Year) 3/7/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL CELANO, MD 6069 N. Charles St, Baltimore MD 21204							
31. DATE FILED (Month, Day, Year) MAR 11 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

6876

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE MEDICAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature or text, possibly "J. H. ..."

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHRISTIE MAUDE SNEAD EVANS				2. DATE OF DEATH MONTH DAY YEAR March 6, 1996		3. TIME OF DEATH 5:09 PM	
4. SOCIAL SECURITY NUMBER 216-05-3310		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1911	
9a. FACILITY NAME (If not institution, give street and number) 615 Chestnut Ave. Apt. 1103				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 615 Chestnut Ave. Apt. 1103				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Univ. of Baltimore			
17. FATHER'S NAME (First, Middle, Last) James S. Clayton Snead				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Alice Coffey			
19a. INFORMANT'S NAME (Type/Print) Mr. William S. Evans				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Chestnut Ave. Apt. 1103 Towson, Md. 21204			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns. 3/11/96 Timonium, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval between Onset and Death 1 day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W.A. Riley, MD				29c. LICENSE NUMBER D25205		29d. DATE SIGNED (Month, Day, Year) 3/7/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W.A. Riley G.B./MC 6701 N. Charles St., Balto. Md 21208							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06787

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DAVID ALEXANDER ECHOLS SR.				2. DATE OF DEATH MONTH MARCH DAY 2 YEAR 1996		3. TIME OF DEATH 3:50 A.M.	
4. SOCIAL SECURITY NUMBER 214-40-8307		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 23, 1901	
8. BIRTHPLACE (State or Foreign Country) Georgia				9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2315 Pennyroyal Terrace	
10f. ZIP CODE 21209-4637				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher-Retired		16b. KIND OF BUSINESS/INDUSTRY Balt. City - Dept. Education			
17. FATHER'S NAME (First, Middle, Last) Judson Echols				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Williams			
19a. INFORMANT'S NAME (Type/Print) David A. Echols Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2315 Pennroyal Terrace Balt. Md. 21209-4637			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National Cemetery 3/8 Price George, Maryland		20c. LOCATION — City or Town, State Price George, Maryland		20d. LOCATION — City or Town, State Price George, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes Inc. 2501 Gwynn Falls PKY Balt. Md. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Prostate Cancer Approximate Interval Between Onset and Death 4 yrs Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE AT MERCY					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. [Signature]				29c. LICENSE NUMBER 240480		29d. DATE SIGNED (Month, Day, Year) March 4, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO, MD 5810 BELAIR RD BALTO., MD 21206							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

perDOCTOR

State of Maryland / Department of Health and Mental Hygiene

96 06788

item#28a&28b film 8733 3/11/96 ag

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Fraternali				2. Date of Death Month Day Year February 15, 1996		3. Time of Death 6:45 AM	
	4a. Facility Name (If not institution, give street and number) 121 Glenmoore Ave.				4b. City, Town, or Location of Death Cockeysville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 234-10-5766		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 22, 1909	9. Birthplace (State or Foreign Country) W. Va.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Cockeysville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 121 Glenmoore Ave.			10f. Zip Code 21030		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Dept.			16b. Kind of Business/Industry Baltimore City		
	17. Father's Name (First, Middle, Last) David Fraternali				18. Mother's Name (First, Middle, Maiden Summa) Camille DeCuora			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia A. Waltman				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Glenmoore Ave. Cockeysville, Md. 21030			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify Entombment)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns, 2/19/96		20c. Location - City or Town, State Timonium, Md.			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on each line. Immediata Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 1 hr.
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Feb. 15, 1996		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D16960		29d. Date signed (Month, Day, Year) Feb. 15, 1996
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Franklin E. Chatham, M.D. 1012 Old North Pt. Rd., Baltimore, Md. 21224								
31. Date filed (Month, Day, Year) MAR 1 1996				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State
Registrar

96 06789

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OTELIA GREEN				2. DATE OF DEATH MONTH MAR DAY 5 YEAR 1996		3. TIME OF DEATH 2330 M	
4. SOCIAL SECURITY NUMBER 213-30-8611		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb 13, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Deaton Specialty Hospital & Home		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH n/a				10a. STATE Maryland		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2540 West Fayette Street				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School		College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Private Duty Nurse		16b. KIND OF BUSINESS/INDUSTRY Medical	
17. FATHER'S NAME (First, Middle, Last) Norman Parker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Hall			
19a. INFORMANT'S NAME (Type/Print) Geraldine Gray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Wicklow Road Baltimore, Maryland 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park		DATE 3/11		20c. LOCATION — City or Town, State Baltimore County, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 1 YR.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE, DEMENTIA							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Brian C. Wallace MD				29c. LICENSE NUMBER D31136		29d. DATE SIGNED (Month, Day, Year) MAR 5, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN C. WALLACE, MD, 611 S. CHARLES ST., BALTIMORE, MD 21230							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE John A. ...			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06790

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSIE Jesse GALLOWAY SR.				2. Date of Death Month Day Year MARCH 6, 1996		3. Time of Death 1:24 PM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 245-10-0634		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 22, 1919	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 126 NORTH HILTON STREET		10f. Zip Code 21229		10g. Citizen of What Country? USA.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REALTOR		16b. Kind of Business/Industry SELF-EMPLOYED			
	17. Father's Name (First, Middle, Last) WILLIAM GALLOWAY		18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN		19a. Informant's Name/Relationship (Type, Print) GERTRUDE GALLOWAY			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 NORTH HILTON STREET, BALTIMORE, MD. 21229		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		20c. Location - City or Town, State WOODLAWN, MARYLAND	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? INSPECTED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certify (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 7, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE M.D. 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) MAR 11 1996							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Thomas Hardy				2. DATE OF DEATH MONTH DAY YEAR MAR 8 1996		3. TIME OF DEATH 0645 A.M.	
4. SOCIAL SECURITY NUMBER 192-18-8817		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-21-19	
8. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9. CITY, TOWN OR LOCATION OF DEATH Baltimore		10. COUNTY OF DEATH N/A	
11. RESIDENCE OF DECEDENT				12. CITY, TOWN OR LOCATION Columbia		13. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
14. STATE Md.		15. COUNTY Howard		16. ZIP CODE 21044		17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. STREET AND NUMBER 6336 Cedar Lane		19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
22. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12		23. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Social Security Dept.		24. 16b. KIND OF BUSINESS/INDUSTRY Federal Government		25. 14. RACE — American Indian, Black, White, etc. Specify: White	
26. 17. FATHER'S NAME (First, Middle, Last) William Hardy				27. 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna McLaughlin			
28. 19a. INFORMANT'S NAME (Type/Print) Mark T. Hardy				29. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Kimball Ct. - Baltimore, Md. 21228			
30. 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cemetery Immaculate Conception - 13-96 Clarion, Pa.		32. 20c. LOCATION — City or Town, State		33. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab	
34. 22. NAME AND ADDRESS OF FACILITY 5151 Baltimore National Pike Baltimore, Md. 21229		35. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				36. Approximate Interval Between Onset and Death	
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIGOXIN TOXICITY						38. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
39. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		42. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
43. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		44. 28a. DATE OF INJURY (Month, Day, Year)		45. 28b. TIME OF INJURY M		46. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
47. 28d. DESCRIBE HOW INJURY OCCURRED		48. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		49. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
50. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
51. 29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				52. 29c. LICENSE NUMBER PO 9143		53. 29d. DATE SIGNED (Month, Day, Year) MARCH 8, 1996	
54. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KAY THI NWE, ST AGNES, 900 CATON AVE, BALTIMORE, MD 21229							
55. 31. DATE FILED (Month, Day, Year) MAR 11 1996		56. 32. REGISTRAR'S SIGNATURE John Andrew Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06791

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maria F Hoffman

2. Date of Death

March 5, 1996

3. Time of Death

7:00P.M.

4a. Facility Name (If not institution, give street and number)

1007 7TH Street

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

212-54-9861

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 5, 1918

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

1007 7TH Street

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Day Care Worker

16b. Kind of Business/Industry

Child Care

17. Father's Name (First, Middle, Last)

Midolo Concetto

18. Mother's Name (First, Middle, Maiden Surname)

Silvia Clelia Salvadori

19a. Informant's Name/Relationship (Type, Print)

Cheryal A. Hussain/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15024 Wheatland Place, Laurel, Maryland 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem. 3/15

Data

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Proximal Myocardial Infarction
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Hypertension / Cerebrovascular accident
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA HUSSAIN ALI SAIG 460-7350 VANDUSEN ROAD LAUREL MD 20707

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

J. B. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

item#4,19b&20b file# g733 3/11/96 ag perFH

Certificate of Death

Reg. No.

96 06793

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Josephine Hines</u>			2. Date of Death Month Day Year <u>March 7, 1996</u>		3. Time of Death <u>9:30 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Bayview Medical Center</u>			4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>217-34-8191</u> <u>217-32-8191</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>59</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>01/27/1937</u>
	9. Birthplace (State or Foreign Country) <u>Maryland</u>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <u>Maryland</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <u>2710 Plainfield Road</u>			10f. Zip Code <u>21222</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Cashier</u>		16b. Kind of Business/Industry <u>Bakery</u>		
	17. Father's Name (First, Middle, Last) <u>Frank Rogowski</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Agnes Kokoszka</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>William H. Hines Husband</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2710 Plainfield Rd. Baltimore, Md 21222</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>St. Stanislaus Cemetery</u>		Date <u>3/9</u>	20c. Location - City or Town, State <u>Baltimore, Maryland</u>	
	21. Signature of Funeral Service Licensee <u>[Signature]</u>			22. Name and Address of Facility <u>David J. Weber Funeral Home</u> <u>401 S. Chester St. Baltimore, Maryland 21231</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)			a. <u>Subarachnoid Hemorrhage</u>		Due to (or as a consequence of):	
	b. <u>Cerebral Aneurysm</u>			Due to (or as a consequence of):		Approximate Interval Between Onset and Death <u>2 days</u>	
	c. _____			Due to (or as a consequence of):		<u>1 year</u>	
	d. _____			Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <u>[Signature] Resident Physician</u>			29c. License number <u>N1243</u>		29d. Date signed (Month, Day, Year) <u>March 7, 1996</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Kevin A. Walter, Bayview Medical Center, Eastern Ave, Baltimore, MD 21224</u>							
31. Date filed (Month, Day, Year) <u>MAR 11 1996</u>			32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

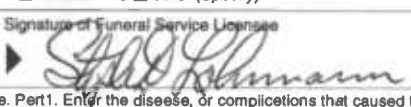
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06794

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KLARE L. HAMBURGER				2. Date of Death Month Day Year MARCH 8 1996		3. Time of Death 3:00AM		
	4e. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 218 18 8372		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 11, 1907		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Cockeysville		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13801 York Rd., Apt. B-17		10f. Zip Code 21030		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic					
17. Father's Name (First, Middle, Last) Ferdinand Phillip		18. Mother's Name (First, Middle, Maiden Surname) Maud Hirsh		19. Informant's Name/Relationship (Type, Print) Dr. Louis P. Hamburger		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13801 York Rd., Apt. B-17, Cockeysville, MD 21030			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 3/9/96		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286							
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		e. Respiratory Insufficiency Due to (or as a consequence of): b. Congestive Heart Failure & Pneumonia Due to (or as a consequence of): c. and possible Ischemic Bowel Disease Due to (or as a consequence of): d. arteriosclerotic vascular disease & Left Pulmonary Thrombus		Approximate Interval Between Onset and Death hours months 2 weeks unknown					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D25182		29d. Date signed (Month, Day, Year) 3-8-96			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) A. Ramzy, MD, 120 Sister Pierre Dr, #501, Towson, MD 21204		31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Martin Hanley				2. DATE OF DEATH MONTH DAY YEAR MARCH 9 1996		3. TIME OF DEATH 7:50 PM	
4. SOCIAL SECURITY NUMBER 212-12-9375		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1922	
6a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				6b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		6c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 20 Lyndale Avenue				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Set Up Man		16b. KIND OF BUSINESS/INDUSTRY Tool & Dye Shop			
17. FATHER'S NAME (First, Middle, Last) Carroll Patrick Hanley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Eva Betz			
19a. INFORMANT'S NAME (Type/Print) Mary Isabel Hanley - Wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Lyndale Avenue Baltimore, Maryland - 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 3/6		20c. LOCATION — City or Town, State Baltimore, Maryland		20d. DATE 3/13/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i>				22. NAME AND ADDRESS OF FACILITY 6415 Belair Road 21206 John C. Miller, Inc. Baltimore, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>PULMONARY EDEMA</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>MULTIPLE MYELOMA</u> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nicole C. Farley MD</i>				29c. LICENSE NUMBER AT 243 8946		29d. DATE SIGNED (Month, Day, Year) MARCH 9 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NICOLE C. FARLEY 29 SOUTH PACA ST. BALTIMORE MD 21001							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE <i>John D. Parker</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

item#1 film g733 3/11/96 ag perFK Certificate of Death

Reg. No.

96 06796

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE
Isabel AA. Judd2. Date of Death
Month Day Year

March 5 1996

3. Time of Death

4:45 A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

230-34-0819

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

February 12, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

Baltimore

10c. City, Town or Location

Fort Howard

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9223 Todd Avenue

10f. Zip Code

21052

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Wilbur Ayers

18. Mother's Name (First, Middle, Maiden Surname)

Susie Miller

19a. Informant's Name/Relationship (Type, Print)

Jack E. Judd

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9223 Todd Avenue Fort Howard, Maryland 21052

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Mem. Ph. 3/8/1996

Date

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Adenocarcinoma of the lung
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

10 days

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

96000

29d. Date signed (Month, Day, Year)

March 5, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Todd J. Baldanz, M.D. JHBMC 4940 Eastern Ave Baltimore, Md. 21224

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DMMH-16 Rev 1/89

96 06798

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lorena D. Lucas				2. DATE OF DEATH MONTH DAY YEAR March 6, 1996		3. TIME OF DEATH 1:15 A M	
4. SOCIAL SECURITY NUMBER 212-14-1474		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-10-1904	
8. BIRTHPLACE (State or Foreign Country) N.C.				9a. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
9b. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				10a. STATE Md			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 501 Dolphin Street			
10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic Work		15b. KIND OF BUSINESS/INDUSTRY Private Homes			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic Work				16b. KIND OF BUSINESS/INDUSTRY Private Homes			
17. FATHER'S NAME (First, Middle, Last) Frank Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Genettie Hollaway			
19a. INFORMANT'S NAME (Type/Print) Elwood Lucas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4901 Belle Avenue Baltimore, Md 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park		20c. DATE 3/12/96		20d. LOCATION — City or Town, State Randallstown, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. E. Edmond				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore, Md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pleural Effusion DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER P. Jonglertham				29c. LICENSE NUMBER 89261		29d. DATE SIGNED (Month, Day, Year) March 6, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Pornchai Jonglertham, M.D. c/o Maryland General Hospital							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE Julia Davidson-Kovall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL: DEPARTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Conrad B. Lambert</i>				2. Date of Death Month <i>March</i> Day <i>8</i> Year <i>1996</i>		3. Time of Death <i>7:01 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital Center</i>				4b. City, Town, or Location of Death <i>Randallstown</i>		4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>219-28-1654</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>62</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 16, 1933</i>		9. Birthplace (State or Foreign Country) <i>Baltimore, MD</i>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>Baltimore Co.</i>		10c. City, Town or Location <i>Reisterstown</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>12100 Tarragon Rd.</i>			10f. Zip Code <i>21136</i>		10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>sales</i>			16b. Kind of Business/Industry <i>insurance</i>			
	17. Father's Name (First, Middle, Last) <i>Conrad Joseph Lambert</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Glory Unknown</i>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Betty L. Lambert</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12100 Tarragon Rd. Reisterstown, MD 21136</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery or other place) <i>LORRAINE Park Cemetery</i>		Date <i>3/12/96</i>		20c. Location - City or Town, State <i>Woodlawn, MD</i>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <i>11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Ventricular Arrhythmia - Tachycardia, arrest</i> Due to (or as a consequence of): b. <i>Bilateral Diabetes Mellitus</i> Due to (or as a consequence of): c. <i>Addison's disease</i> Due to (or as a consequence of): d. <i>Coronary Vascular disease</i>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Hypercholesterolemia</i>								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Craig G. Haber, M.D.</i>			29c. License number <i>D24866</i>		29d. Date signed (Month, Day, Year) <i>3/8/96</i>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Craig G. Haber, M.D. 210 Business Center Dr. Reisterstown, Md. 21136</i>								
	31. Date filed (Month, Day, Year) <i>MAR 11 1996</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06800

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DARRELL LAWSON JR.				2. Date of Death Month Day Year MARCH 01, 1996		3. Time of Death 3:20 PM	
	4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL E.R.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-45-1096	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 2	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 27, 1995		9. Birthplace (State or Foreign Country) Maryland
	10a. State MD							
To Be Completed by Funeral Director	10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 2033 BOYD ST.				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) DARRELL LAWSON				18. Mother's Name (First, Middle, Maiden Surname) KIMBERLY SCOTT			
	19a. Informant's Name/Relationship (Type, Print) KIMBERLY LAWSON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2033 BOYD ST. BALT. MD. 21223			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		20c. Location - City or Town, State 3996 LANSDOWNE MD.		20d. Date 3/9/96	
	21. Signature of Funeral Service Licensee GARY P. MARCH FUNERAL HOME P.A.				22. Name and Address of Funeral Home 2701 FREDERICK BLVD BALT. MD. 21229			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or cause failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUDDEN INFANT DEATH SYNDROME (SIDS) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier O.C.M.E.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 02, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) MAR 11 1996				32. Registrar's Signature John A. ...			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.



96 06801

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARION LEWIS				2. Date of Death Month March Day 7 Year 1996		3. Time of Death 11 AM	
	4a. Facility Name (If not institution, give street and number) 1478 Algonquin Court				4b. City, Town, or Location of Death Finksburg		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 212-70-4788		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) March 9, 1957	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Finksburg	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 1478 Algonquin Court				10f. Zip Code 21048		10g. Citizen of What Country? United States	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 year		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Secretary		16b. Kind of Business/Industry Maryland State Police			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Carroll Irving Stewart				18. Mother's Name (First, Middle, Maiden Surname) Annie Navata Denton			
	19a. Informant's Name/Relationship (Type, Print) Thomas H. Lewis (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1478 Algonquin Court Finksburg, MD 21048			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park		20c. Location - City or Town, State March 10, 1996 Cambridge, Maryland			
	21. Signature of Funeral Service Licensee Joseph J. Kellner		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd Randallstown, Maryland 21133-4784					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Adrenal Cancer							Approximate Interval Between Onset and Death 4 1/2 YRS.
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospitel: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Enser W. Cole				29c. License number D16354		29d. Date signed (Month, Day, Year) 3/7/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Enser W. Cole 900 Bestgate Rd Suite 300 Annapolis, MD 21401							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) MAR 11 1996				32. Registrar's Signature Julia Hunter-Russell			

96 06802

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY LANDERGREN JR				2. DATE OF DEATH MONTH Mar DAY 8 YEAR 1996		3. TIME OF DEATH 8:23 pm	
4. SOCIAL SECURITY NUMBER 215-32-3545		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 18, 1935	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Villa Nova				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4011 Buckingham Rd.	
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Oct. 2, 1961 - Aug. 1, 1962		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painting Contractor		16b. KIND OF BUSINESS/INDUSTRY Painting - Self Employed			
17. FATHER'S NAME (First, Middle, Last) Henry J. E. Landergren Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Cernak			
19a. INFORMANT'S NAME (Type/Print) Diana W. Landergren (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011 Buckingham Rd. Baltimore, MD 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. LOCATION — City or Town, State 3-12 Woodlawn, Maryland		20d. DATE 3-12	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MESOTHELIOMA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ASBESTOS EXPOSURE c. d. Approximate Interval Between Onset and Death 3 YEARS Uncertain						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Beatriz P. Dizon, M.D.			
29c. LICENSE NUMBER D16492				29d. DATE SIGNED (Month, Day, Year) March 8, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEATRIZ P. DIZON, M.D., ST. JOSEPH MEDICAL CENTER, 7620 YORK ROAD, TOWSON, MD. 21204							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06803

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FELICIA PAVLETTE LEMON				2. Date of Death Month MARCH Day 04 Year 1996		3. Time of Death 1403	
	4e. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-18-8184		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 20, 1920	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 5205 BOSWORTH AVENUE		10f. Zip Code 21207	
	10g. Citizen of What Country? USA.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BEAUTICIAN				16b. Kind of Business/Industry SELF-EMPLOYED			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOSEPH H. JOHNSON				18. Mother's Name (First, Middle, Maiden Surname) SARAH E. BRYAN			
	19a. Informant's Name/Relationship (Type, Print) HAROLD LEMON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5205 BOSWORTH AVE., BALTIMORE, MD - 21207			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL 3-8-96 BALTIMORE, MD.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST. BALTIMORE, MD. 21223			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION						Approximate Interval Between Onset and Death	
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYERTENSION, DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE, SICK SINUS SYNDROME, CEREBROVASCULAR ACCIDENT						23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier 	
	29c. License number AS2402321 PS9945						29d. Date signed (Month, Day, Year) MARCH 04, 1996	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL SEGAL 2401 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND						31. Date filed (Month, Day, Year) MAR 11 1996	
	32. Registrar's Signature 						33. Registrar's Title PAUL SEGAL	

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the practical applications of the findings and a suggestion for further research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

96 06804

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary A. LEWIS				2. DATE OF DEATH MONTH March DAY 8 YEAR 1996		3. TIME OF DEATH 4:35pm	
4. SOCIAL SECURITY NUMBER 219-28-5917		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Mar 26, 1910	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) ST. ELIZABETH'S		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH BALTIMORE CITY				10a. STATE MD		10b. COUNTY BALTIMORE CO.	
10c. CITY, TOWN OR LOCATION RELAY				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5119 SOUTH ROLLING RD	
10f. ZIP CODE 21227				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES		16b. KIND OF BUSINESS/INDUSTRY RETAIL	
17. FATHER'S NAME (First, Middle, Last) GREGORY WIEGARD				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA RAUSCH			
19a. INFORMANT'S NAME (Type/Print) GEORGE E. LEWIS SON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5119 SOUTH ROLLING RD, RELAY, MD 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY 3/12/96		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY AMBROS FUNERAL HOME 1328 SULLYVA SPRING RD, ARDMORE 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. aspiration, probable DUE TO (OR AS A CONSEQUENCE OF): b. vomiting - gastroenteritis DUE TO (OR AS A CONSEQUENCE OF): c. dementia, multifactor DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 2-3 Days WK YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kris E. Kuhn, MD</i>				29c. LICENSE NUMBER D37464		29d. DATE SIGNED (Month, Day, Year) 3/9/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KRIS E. KUHN, M.D. ST. ELIZABETH'S, 3320 BENSON AVE, BALTO. MD 21227							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06805

item# 3 file# g733 3/11/96 ag per FH

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Little

LOIS VIVIAN CLARK LITTLE

2. Date of Death

Month

Day

Year

March

6

1996

3. Time of Death

1:25 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

218-28-0014

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inade City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2316 North Longwood Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Family

17. Father's Name (First, Middle, Last)

John Clark

18. Mother's Name (First, Middle, Maiden Surname)

Alma Fowler

19a. Informant's Name/Relationship (Type, Print)

Cecil C. Little

(daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Rita Drive Mt. Sinai, NY 11760-2217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veteran Cem

Date

March 11

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls Parkway

Baltimore, Maryland 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxic Encephalopathy

Due to (or as a consequence of):

b. Pulmonary Edema

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d. Hypertensive Cardiovascular Disease

Approximate Interval Between Onset and Death

6 days

5 days

10 years

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Renal Insufficiency

Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

House Officer

29c. License number

AS2441614-43

29d. Date signed (Month, Day, Year)

March 6 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr XIAO-MING ZHOU 3001 S. Hanover St. Baltimore, MD

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96-1081-510

Item 6 3-11-96 Film G733 W.H. Per F/H

ITEMS: 23 PART I, II Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

asp 27, PER MEO FILM G-733 3/15/96 State of Maryland / Department of Health and Mental Hygiene

96 06806

UNK 96-040

item #10 of film g733 3/13/96 ag per Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE JAMES LYNN

2. Date of Death

FEB 29 Day 1996 Year

3. Time of Death

6:13 A

4a. Facility Name (If not institution, give street and number)

1530 N. BAKER ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

237-50-5373

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 8, 1933

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 WEST 20TH STREET

10f. Zip Code

21218

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
UNKNOWN

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

ICE CREAM COMPANY

17. Father's Name (First, Middle, Last)

HENRY LYNN

18. Mother's Name (First, Middle, Maiden Surname)

PEARL WILLIAM

19a. Informant's Name/Relationship (Type, Print)

RUBY LYNN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1419 N. DUKELAND ST., BALTIMORE MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

WESTERN STAR CEMETERY 3-6-96 CATONSVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D. Brown

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
1913 W. BALTO. ST., BALTIMORE, MD. 2122323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PULMONARY THROMBO-EMBOLISM

Due to (or as a consequence of):

b. DEEP VEIN THROMBOSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SQUAMOUS CELL CARCINOMA OF ESOPHAGUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 29, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

06807

item#18,5 film g733 3/13/96 ag State of Maryland / Department of Health and Mental Hygiene

perFH Filing, 733, item #20c, 3/15/96, cyw, per fh
item#20b film g733 3/11/96 ag perFH Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) WARREN S. MURRAY		2. Date of Death Month March Day 5 Year 1996		3. Time of Death 1:30 p.m.	
4a. Facility Name (If not institution, give street and number) 710 ROUNDVIEW ROAD		4b. City, Town, or Location of Death Balto		4c. County of Death NIA	
5. Social Security Number 218-26-4319		6. Sex M <input type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 65 Yrs.	
8. Date of Birth (Month, Day, Year) Jan 7, 1931		9. Birthplace (State or Foreign Country) md			
Usual Residence of Decedent					
10a. State md		10b. County NIA		10c. City, Town or Location Balto	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 710 Roundview Rd		10f. Zip Code 21225	
10g. Citizen of What Country? U.S.A		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) POE College (1-4 or 5+) NIA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tow Driver		16b. Kind of Business/Industry Harbison Walker - Refractory	
17. Father's Name (First, Middle, Last) alfred Murray		18. Mother's Name (First, Middle, Maiden Surname) MAE CARLESTER MURRAY			
19a. Informant's Name/Relationship (Type, Print) Florence Murray - wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Roundview Rd Balto, md 21225			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem Pl		20c. Location - City or Town, State Glen Burnie	
21. Signature of Funeral Service Licensee Gabrielle Cook		22. Name and Address of Facility March H. West 4300 Wabash Ave			
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
e. LIVER FAILURE					
Due to (or as a consequence of):					
f. OBSTRUCTIVE BRONCHITIS					
Due to (or as a consequence of):					
g. CALCULI OF PANCREAS					
Due to (or as a consequence of):					
h. HEART OF PANCREAS					
Due to (or as a consequence of):					
Approximate Interval Between Onset and Death					
i. WEEKS					
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06808

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIUS D. MILLER

2. Date of Death
Month Day Year

MARCH 6 1996

3. Time of Death
3:45 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-16-5462

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 14, 1922

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State
MD

10b. County
NA

10c. City, Town or Location
Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2730 Parkwood Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

11th grade

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mortar Mixer

16b. Kind of Business/Industry

Construction Co.

17. Father's Name (First, Middle, Last)

Benjamin Miller

18. Mother's Name (First, Middle, Maiden Summa)

Myona Miller

19a. Informant's Name/Relationship (Type, Print)

Margaret Miller wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2730 Parkwood Avenue Balt, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park

Date

3/11/96

20c. Location - City or Town, State

Balt, MD

21. Signature of Funeral Service Licensee

Portia Elton

22. Name and Address of Facility

March F. H. West
4300 Wabash Avenue Balt, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

WKS

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hx CARDIAC ARREST (x2)

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

March F. H. West

29c. License number

D45757

29d. Date signed (Month, Day, Year)

MAR 6, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W. Belvedere

Balt, MD

21215

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

Julia D. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06809

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Vinson Maring

2. Date of Death
Month Day Year

March 6, 1996

3. Time of Death

12:41 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

226-42-2902

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 6, 1912

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6336 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Veterans Cemetery

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Perry

19a. Informant's Name/Relationship (Type, Print)

Robert B. Maring/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15406 Alan Drive, Laurel, Maryland 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

3/12

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subarachnoid Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Lorenzo Marcolin MD

29c. License number

D08054

29d. Date signed (Month, Day, Year)

3/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORENZO MARCOLIN M.D., 121 Congressional Lane, Belville

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

17 + 1

C
VOID

CERTIFICATE 88

96-06810

SEE

CERTIFICATE 88

95.41449

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06811

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL ANTHONY MATISZ

2. Date of Death

MARCH 9, 1996

3. Time of Death

4:05 P.M.

4a. Facility Name (If not institution, give street and number)

329 JOPLIN STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

163-20-0312

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07 09 26

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

329 JOPLIN STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CRANE OPERATOR

16b. Kind of Business/Industry

STEEL

17. Father's Name (First, Middle, Last)

MICHAEL MATISZ

18. Mother's Name (First, Middle, Maiden Surname)

ANNA KREJCIK

19a. Informant's Name/Relationship (Type, Print)

RUTH A. MATISZ, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

329 JOPLIN ST. BALTO. MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLY HILLS MEMORIAL PARK

Date

3-11-96

20c. Location - City or Town, State

MIDDLE RIVER, MD.

21. Signature of Funeral Service Licensee

Charles D. Zeller

22. Name and Address of Facility

CHARLES S. ZEILERTSON INC.
6224 EASTERN AVE. BALTO. MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Prostate Cancer

Approximate Interval Between Onset and Death

Sept '94

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gayatri D. Nimmagadda

29c. License number

D 39041

29d. Date signed (Month, Day, Year)

03 / 11 / 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAYATRI D. NIMMAGADDA

Harbor Hospital Center MD 21225
3501 S. Hanover Street Baltimore

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

per doctor State of Maryland / Department of Health and Mental Hygiene
item#23a film g733 3/25/96 ag Certificate of Death

Reg. No. 96 06812

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Joseph D Moore		2. Date of Death Month Mar Day 2 Year 96		3. Time of Death 1425
4a. Facility Name (If not institution, give street and number) UNIV of Maryland Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death NA
5. Social Security Number 230-03-5798	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
6. Usual Residence of Decedent 10a. State Maryland 10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2939 Boarman Ave.		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: NA		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labor		16b. Kind of Business/Industry Beth Steel
17. Father's Name (First, Middle, Last) Johnnie Moore		18. Mother's Name (First, Middle, Maiden Surname) ELIZA MOORE		
19a. Informant's Name/Relationship (Type, Print) Delores Thompson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2839 Boarman Ave Balto. Md. 21215		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT Zion Cemetery		20c. Location - City or Town, State Landowe, Md
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Sett Miller P.C.F./H 1639 N. Broadway Balto. Md.		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Renal FAILURE Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 1 month years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier [Signature] MD		29c. License number D24170		29d. Date signed (Month, Day, Year) Mar 2 1996
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. TSO MD UNIV OF MARYLAND HOSP. BALTIMORE MD 21201				
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature [Signature]		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06813

item#20b 3/11/96 film g733 ag perFH Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP MOORE				2. Date of Death Month MARCH Day 08 Year 1996		3. Time of Death 7:45 AM	
	4a. Facility Name (If not institution, give street and number) 2452 JOSEPH AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 237-36-3512		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) 07/15/28	
	9. Birthplace (State or Foreign Country) N.C.		10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2452 Joseph Ave.		10f. Zip Code 21225		10g. Citizen of What Country? U.S.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Abe Moore		18. Mother's Name (First, Middle, Maiden Summa) Rose Higgins		19. Informant's Name/Relationship (Type, Print) Marjorie Moore			
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Balto. Md.		20d. Date 3/8/96	
	21. Signature of Funeral Service Licensee <i>Robert M. Wainwright</i>		22. Name and Address of Facility Wainwright Funeral Home 700 Edmondson Ave. Balto. Md. 21223					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To the Registrar	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Margarita Korell</i>					
State Registrar	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 08, 1996					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature <i>John Davidson Rusk</i>					

96 06814

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <i>Richard A. McCall</i>				2. DATE OF DEATH MONTH <i>MAR</i> DAY <i>4</i> YEAR <i>96</i>		3. TIME OF DEATH <i>2:00 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-52-2216</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>47</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 9, 1948</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Church Home Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>n/a</i>				10a. STATE <i>Maryland</i>			
10b. COUNTY <i>n/a</i>				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1200 Lindenleaf Court</i>			
10f. ZIP CODE <i>21202</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th Grade</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Landscaper</i>		16b. KIND OF BUSINESS/INDUSTRY <i>City of Baltimore</i>	
17. FATHER'S NAME (First, Middle, Last) <i>James McCall</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Luretha Harlee</i>			
19a. INFORMANT'S NAME (Type/Print) <i>James McCall</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1200 Lindenleaf Court Baltimore, MD 21202</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt Zion Cemetery</i>		DATE <i>3/9</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin Parker</i>				22. NAME AND ADDRESS OF FACILITY <i>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>AIDS - Wasting Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>months</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul E. Gormley MD</i>				29c. LICENSE NUMBER <i>D18587</i>		29d. DATE SIGNED (Month, Day, Year) <i>MAR 4 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul E. Gormley 100 N Broadway Balt. MD 21231</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 11 1996</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06815

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELSIE D. MOORE		2. Date of Death Month March Day 7 Year 96		3. Time of Death 6:15 PM
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death NA
Funeral Director	5. Social Security Number 226-46-6259	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	8. Date of Birth (Month, Day, Year) 9-20-31	9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 5814 Falkirk Rd		10f. Zip Code 21239	10g. Citizen of What Country? USA	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) NA		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) catering		16b. Kind of Business/Industry Food Service		
	17. Father's Name (First, Middle, Last) James Weaver		18. Mother's Name (First, Middle, Maiden Surname) Gracie Duggar		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lewis N. Moore, Sr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5814 Falkirk Rd. Balto.MD, 21239		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet.		20c. Location - City or Town, State 3/13/96 Owings Mills, MD
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Albert P. Wylie Funeral Home, P.A. 638 N. Gilmore St. Balto.MD 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrest Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes ↑ Cudsteel Hypertension				
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day, Year)		28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number D23829		29d. Date signed (Month, Day, Year) 3/8/96
	30. Name and address of person who completed cause of death (item 23e) (Type, Print) 515 FARMINGTON AVE SUITE 330 TOWSON MD 21286				
State Registrar	31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06816

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE

NELSON

2. Date of Death
Month Day Year

MARCH 7, 1996

3. Time of Death

11:58PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

425-80-5442

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

MAY 20, 1942

9. Birthplace (State or Foreign Country)

MISSISSIPPI

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2824 ASHLAND AVENUE

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: BLACK15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10THCollege (1-4or 5+)
N/A18a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

JUICE TESTER

16b. Kind of Business/Industry

JUICE CO,

17. Father's Name (First, Middle, Last)

WALTER NELSON

18. Mother's Name (First, Middle, Maiden Surname)

LEATHA STUMPS

19a. Informant's Name/Relationship (Type, Print)

JULIE JAMISON -SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11851 S. LAFAYETTE ST. CHICAGO, Ill. 60628

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place) 3-14-96 Date
LAGRANGE CEMETERY MAR. ,1996

20c. Location - City or Town, State

NATCHEZ, MISS.

21. Signature of Funeral Service Licensee

Calvin B. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

lung cancer

Due to (or as a consequence of):

Approximate interval Between Onset and Death

1 year

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dilated cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Calvin B. Scruggs

29c. License number

N2619

29d. Date signed (Month, Day, Year)

March 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isaac F. Silverman, M.D. Johns Hopkins Hospital; 110 Tower, 600 N. Wolfe St.; Baltimore, MD 21287

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature

*John B. ...*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06817

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD ALLEN PROPHET

2. Date of Death

MAR 7 1996

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

1020 CECIL AVE

4b. City, Town, or Location of Death

MILLERSVILLE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

216-80-7716

6. Sex

1 ☐ M 2 ☐ F
X

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 24, 1960

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1020 CECIL AVE

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BRICK MASON

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

CHARLES C. PROPHET

18. Mother's Name (First, Middle, Maiden Surname)

THERESA GIES

19a. Informant's Name/Relationship (Type, Print)

THERESA GIES PROPHET MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 HANFORD DR HARMANS, MD 21077

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OUR LADY OF THE FIELDS

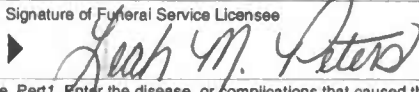
Date

3/11/96

20c. Location - City or Town, State

MILLERSVILLE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

RAYMOND C. FINK FUNERAL HOME

426 CRAIN HWY SW GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON-HODGKINS LYMPHOMA, END-STAGE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

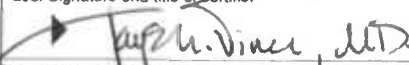
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D47034

29d. Date signed (Month, Day, Year)

3/8/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAYE L. VINER

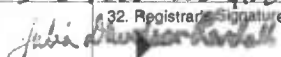
NATIONAL CANCER INSTITUTE, NATIONAL INSTITUTES OF HEALTH
9000 ROCKVILLE PIKE, BUILDING 10 ROOM 12N226

BETHESDA, MD 20892

31. Date filed (Month, Day, Year)

MAR 11 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

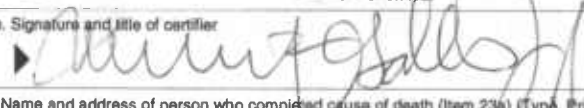
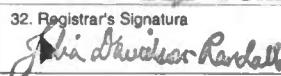
State of Maryland / Department of Health and Mental Hygiene

96 06818

item# 2 film g733 ag 3/11/96 per FH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH William PEEBLES		2. Date of Death Month FEBRUARY Day 26 Year 1996		3. Time of Death 11:35AM
	4a. Facility Name (If not institution, give street and number) 3902 FORD LEIGH ROAD #D		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a
Funeral Director	5. Social Security Number 131-09-5386	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 11 1918		9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10e. State Maryland	10b. County n/a	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 3209 Fordleigh Road Apt. D		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		16b. Kind of Business/Industry General Electric		
	17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) Ada Mills		
	19a. Informant's Name/Relationship (Type, Print) Yvonne Peebles (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 South Durand Place Irvington, NJ 07111		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Mar 7 Catonsville, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore Maryland 21216		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? INSPECTED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 
29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) FEBRUARY 26, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLLE JR. M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAR 1 1996		32. Registrar's Signature 			

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a summary of the main findings.

6. The sixth part is a list of the authors and their affiliations.

7. The seventh part is a list of the titles of the papers.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06819

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RONALD POWELL				2. Date of Death Month Day Year MARCH 03, 1996		3. Time of Death 0236AM			
	4a. Facility Name (If not institution, give street and number) 921 STOLL STREET				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death			
Funeral Director	5. Social Security Number 213-96-7019		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 15 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 9, 1980			
	9. Birthplace (State or Foreign Country) MARYLAND									
Usual Residence of Decedent										
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2115 SIDNEY AVENUE			10f. Zip Code 21230			10g. Citizen of What Country? USA.				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th GRADE College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry HIGH SCHOOL				
17. Father's Name (First, Middle, Last) JAMES PALMER				18. Mother's Name (First, Middle, Maiden Surname) DEBRAH POWELL						
19a. Informant's Name/Relationship (Type, Print) JAMES PALMER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 SIDNEY AVENUE, BALTIMORE, MD. 21230						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 3-8-96 BALTIMORE, MD.						
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223						
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple gunshot wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3-3-96		28b. Time of Injury UNKN		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT SHOT		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) 921 Stoll St. Baltimore						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 03, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Am Dixon 111 Penn Street, Baltimore, Maryland 21201										
31. Date Filed (Month, Day, Year) MAR 11 1996				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

96 06820

item#6 filmg733 3/11/96 ag perFH

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES A. REID				2. DATE OF DEATH MONTH 3 DAY 1 YEAR 1996		3. TIME OF DEATH 14.40 PM	
4. SOCIAL SECURITY NUMBER 078-12-4472		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-21-1919	
9a. FACILITY NAME (If not institution, give street and number) LAUREL REGIONAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LAUREL		9c. COUNTY OF DEATH PRINCE GEORGE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3523 LESLIE WAY #2,				10f. ZIP CODE 20724		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1944 - 1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY SELF-EMPLOYED			
17. FATHER'S NAME (First, Middle, Last) GEORGE REID				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA DeMARSE			
19a. INFORMANT'S NAME (Type/Print) ETHEL REID				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3523 LESLIE WAY, #2, LAUREL, MARYLAND 20724			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE WASHINGTON CREM 3/3		20c. LOCATION — City or Town, State LAUREL, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Perforated Sigmoid Colon DUE TO (OR AS A CONSEQUENCE OF): Ischemic Bowel DUE TO (OR AS A CONSEQUENCE OF): Generalized arteriosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> AM <input type="checkbox"/> PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER MD08307		29d. DATE SIGNED (Month, Day, Year) 3/1/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DETAKY MOURTZANAKIS 3450 FORT MEADERD, LAUREL MD							
31. DATE FILED (Month, Day, Year) MAR 1 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEN RIVERS				2. DATE OF DEATH MONTH Feb DAY 21 YEAR 1996		3. TIME OF DEATH 4:41 P.M.	
4. SOCIAL SECURITY NUMBER 579-70-1412		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 9, 1953	
8. BIRTHPLACE (State or Foreign Country) WASH. D.C.				9a. FACILITY NAME (If not institution, give street and number) BON SECOUR		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MD		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 847 NEBRASKA COURT	
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12TH College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY TRUCK	
17. FATHER'S NAME (First, Middle, Last) FRANK RIVERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROBERTA LEE JOHNSON			
19a. INFORMANT'S NAME (Type/Print) SHIRLEY RIVERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 847 NEBRASKA COURT BALT, MD, 21225			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) 116130		20c. LOCATION — City or Town, State BALT, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY GARY P. MARSH FUNERAL HOME P.A. 220 FREDERICK AVE BALT, MD 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → EMPHYSEMA, LEFT Approximate Interval Between Onset and Death 4 weeks Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PNEUMONIA, LEFT LUNG Approximate Interval Between Onset and Death 5 weeks a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALCOHOLISM GASTRIC BLEEDING HIV POSITIVE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D06812		29d. DATE SIGNED (Month, Day, Year) Feb 23, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) F.S. LEACOCK 4820 SETON DRIVE SUITE A BALT MD 21225							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06822

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gladys Rudolph				2. DATE OF DEATH MONTH March DAY 7 YEAR 1996		3. TIME OF DEATH 11:55 p.m.	
4. SOCIAL SECURITY NUMBER 218-32-6331		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 1907		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3718 Echodale Avenue				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Samuel Kelly Shannahan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Seymour			
19a. INFORMANT'S NAME (Type/Print) Gilbert J. Rudolph (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 Echodale Avenue Baltimore, Md. 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 3/11/96		20c. LOCATION — City or Town, State Baltimore Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J. Knight Jr.				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): 2-3 weeks							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Sireesh Tripuraneni				29c. LICENSE NUMBER D 30661		29d. DATE SIGNED (Month, Day, Year) March 8th 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sireesh Tripuraneni M.D. 5670B The Alameda Baltimore, Maryland							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located in the center of the page.

96 06823

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED ROBINSON				2. DATE OF DEATH MONTH DAY YEAR March 8, 1996				3. TIME OF DEATH 7:30 p M													
4. SOCIAL SECURITY NUMBER 218-22-3707		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) JAN 18, 1912	8. BIRTHPLACE (State or Foreign Country) MARYLAND																
9a. FACILITY NAME (If not institution, give street and number) RIVERVIEW NURSING CENTRE, INC.				9b. CITY, TOWN OR LOCATION OF DEATH ESSEX			9c. COUNTY OF DEATH BALTO. COUNTY														
RESIDENCE OF DECEDENT																					
10a. STATE MD		10b. COUNTY HARFORD		10c. CITY, TOWN OR LOCATION JOPPA			10d. INSIDE CITY LIMITS? 1 X YES 2 NO														
10e. STREET AND NUMBER 408 DAMBY TOWN ROAD				10f. ZIP CODE 21085		10g. CITIZEN OF WHAT COUNTRY? United states															
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 X Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK														
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC			16b. KIND OF BUSINESS/INDUSTRY PRIVATE														
17. FATHER'S NAME (First, Middle, Last) EUGENE SAMPSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTINA CAMPER																	
19a. INFORMANT'S NAME (Type/Print) MARGARET SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 DEMBY TOWN ROAD JOPPA, MD 21085																	
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEM 3-11-96			20c. LOCATION — City or Town, State balto., Md																
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY 270 FREDHILTON PASS CALVIN L. WILLIAMS F.S. BALTO., MD																	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio Resp ARREST Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a. Dementia old</td> <td>b. 4-5 yrs.</td> <td>c. 1-2 yrs.</td> </tr> <tr> <td colspan="3">DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td colspan="3">d. Older</td> </tr> <tr> <td colspan="3">DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> </table>								a. Dementia old	b. 4-5 yrs.	c. 1-2 yrs.	DUE TO (OR AS A CONSEQUENCE OF):			d. Older			DUE TO (OR AS A CONSEQUENCE OF):			Approximate Interval Between Onset and Death 1-2 hrs. 4-5 yrs. 1-2 yrs.	
a. Dementia old	b. 4-5 yrs.	c. 1-2 yrs.																			
DUE TO (OR AS A CONSEQUENCE OF):																					
d. Older																					
DUE TO (OR AS A CONSEQUENCE OF):																					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 X Nursing Home 5 Residence 6 Other (Specify)																			
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED													
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																	
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 14221		29d. DATE SIGNED (Month, Day, Year) 3. 9. 96															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. A. Brown 223 R. Hwy Baltimore 21221																					
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>																	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

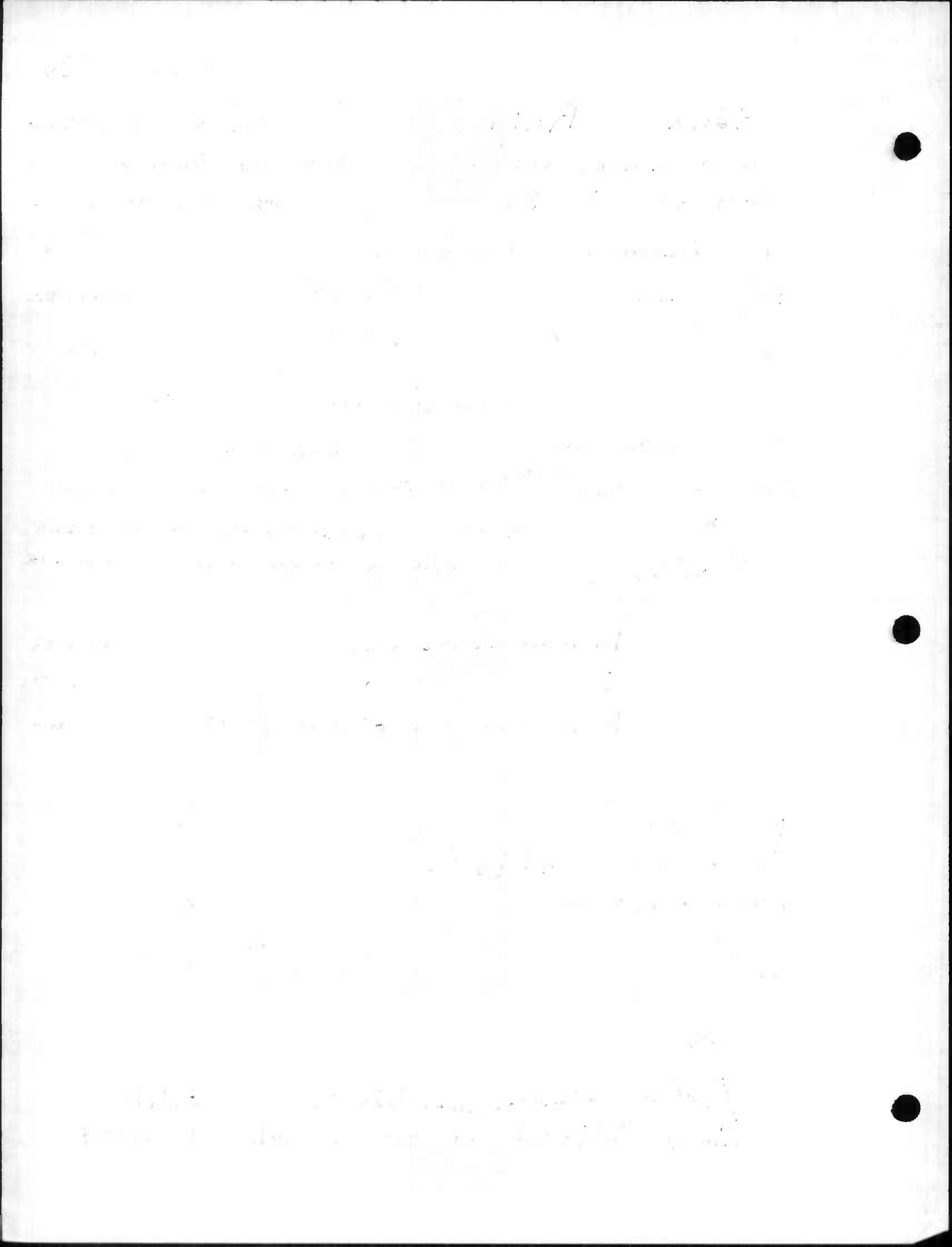
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06824

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Reid				2. Date of Death Month MAR Day 8 Year 1996		3. Time of Death 12:15P.M.	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 213-34-8437		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) AUG 2 1911	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location LANSDOWNE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 819 5TH AVE		10f. Zip Code 21227		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIETARY AIDE		16b. Kind of Business/Industry HOSPITAL			
	17. Father's Name (First, Middle, Last) JOSEPH YOUNG CARSON				18. Mother's Name (First, Middle, Maiden Surname) EVE BIGGERSTAFF			
	19a. Informant's Name/Relationship (Type, Print) DAUGHTER BARBARA ZIEGLER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 5TH AVE, LANSDOWNE, MD 21227			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY MAR, 1996 BALTO, MD 21228		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility AMBROS FURNAL HOME OF LANSDOWNE 2719 HAMMONS FERRY RD, LANSDOWNE 21227			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Abdominal Abscess Due to (or as a consequence of): b. Colonic Fistula Due to (or as a consequence of): c. Metastatic Adenocarcinoma of Colon Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 month 1 month 2 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Congestive Heart Failure Malnutrition							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier - attending physician		29c. License number D26203		29d. Date signed (Month, Day, Year) 3/9/96			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jorge Vallecillo, MD 4000 Annapolis Rd 21227							
	31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06825

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALBERT R. STEVENSON SR.				2. Date of Death Month Day Year MARCH 02, 1996		3. Time of Death 1330 PM	
	4a. Facility Name (If not institution, give street and number) 817 WEST SARATOGA STREET APT. #11				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 212-18-8039		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) March 12 1905	
	9. Birthplace (State or Foreign Country) S.C.		10a. State Md		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 817 W. Saratoga St. Apt. 11		10f. Zip Code 21201		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Produce Market		17. Father's Name (First, Middle, Last) unknown	
	18. Mother's Name (First, Middle, Maiden Surname) unknown		19a. Informant's Name/Relationship (Type, Print) Willie S. Stevenson - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7683 Crilley Road Glen Burnie Md 21061		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Date 3-9-96		20d. Location - City or Town, State Baltimore Md		21. Signature of Funeral Service Licensee Bladys Wane	
	22. Name and Address of Facility March Funeral Home - West 4300 Wabash Ave. Baltimore Md. 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier DR. DAVID FOWLER	
	29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 02, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID FOWLER 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) MAR 11 1996	
32. Registrar's Signature John D. ...		33. Registrar's Signature						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

96 06826

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marion C. Smith				2. DATE OF DEATH MONTH DAY YEAR March 08, 1996				3. TIME OF DEATH 6:25 P.M.					
4. SOCIAL SECURITY NUMBER 098-30-1808		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 18 1908		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) Sunrise Of Towson				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore Co.					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 7925 York Rd.				10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher				16b. KIND OF BUSINESS/INDUSTRY Education					
17. FATHER'S NAME (First, Middle, Last) George Cooper						18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Breininger							
19a. INFORMANT'S NAME (Type/Print) Mary Ann Stobo (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Charlocoat Pl. Baltimore, Md. 21218									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 3/11				20c. LOCATION — City or Town, State Towson, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal failure, chronic DUE TO (OR AS A CONSEQUENCE OF): b. Bladder carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d. — Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death one year ~ 2 1/2 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis, cerebral and coronary Hypertension DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED N/A			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D44290			29d. DATE SIGNED (Month, Day, Year) March 09, 1996				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy L. Krohe, M.D. 8019 York Rd, Towson, MD 21204													
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RITA SHIFFLETT RITA COLEY SHIFFLETT				2. DATE OF DEATH MONTH DAY YEAR MARCH 05 96		3. TIME OF DEATH 6:06 PM	
4. SOCIAL SECURITY NUMBER 233-34-6401		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 29, 1922	
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 826 Jay Dee Avenue				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Food Industry			
17. FATHER'S NAME (First, Middle, Last) Henry Hope				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Jones			
19a. INFORMANT'S NAME (Type/Print) Mr. Ellis F. Shifflett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 826 Jay Dee Avenue Dundalk, Maryland 21222			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Mausoleum 3/9/1996		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Emphysema DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER 96005		29d. DATE SIGNED (Month, Day, Year) MARCH 05, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Steven O. Gigliotti Johns Hopkins Bayview Medical Ctr. Baltimore, MD 21224							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06828

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Cornelia E. Simon</i>				2. DATE OF DEATH MONTH DAY YEAR <i>March 9 1996</i>		3. TIME OF DEATH <i>12:45 A</i>	
4. SOCIAL SECURITY NUMBER <i>087-38-8830</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>AUG. 12, 1922</i>	
8. FACILITY NAME (If not institution, give street and number) <i>LEVINDALE GERIATRIC CENTER</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i>		10. BIRTHPLACE (State or Foreign Country) <i>GYANA SOUTHAMERICA</i>	
11. RESIDENCE OF DECEDENT 10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE CITY</i>	
10d. STREET AND NUMBER <i>4627 PARK HEIGHTS AVE.</i>				10e. ZIP CODE <i>21215</i>		10f. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATHS		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10TH</i>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>		17. KIND OF BUSINESS/INDUSTRY <i>HOME</i>			
18. FATHER'S NAME (First, Middle, Last) <i>JOSEPH WADE</i>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <i>HILDA BART</i>			
20. INFORMANT'S NAME (Type/Print) <i>GEM JAMES - DAUGHTER</i>				21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4627 PARK HEIGHTS AVE. BALTO, MD. 21215</i>			
22. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>REMOVAL FROM COUNTRY/ ST. SWITHIN'S CEM. GYANA, SOUTH AMERICA</i>		24. LOCATION — City or Town, State <i>GYANA, SOUTH AMERICA</i>			
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>		26. NAME AND ADDRESS OF FACILITY <i>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</i>					
27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Atrial fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atherosclerotic Heart disease -</i> DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>≈ 1 yr</i> <i>≈ 1 yr</i> <i>≈ 1 yr</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							28. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
29. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
31. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		32. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
33. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		34. DATE OF INJURY (Month, Day, Year)		35. TIME OF INJURY M		36. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
37. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		38. DESCRIBE HOW INJURY OCCURRED					
39. LOCATION (Street and Number or Rural Route Number, City or Town, State)		40. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
41. SIGNATURE AND TITLE OF CERTIFIER <i>Phyllis</i>		42. LICENSE NUMBER <i>D44817</i>		43. DATE SIGNED (Month, Day, Year) <i>MARCH 9 1996</i>			
44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SUNIL P. RAJANI 2434 W Belvedere Ave, Baltimore</i>							
45. DATE FILED (Month, Day, Year) <i>MAR 11 1996</i>		46. REGISTRAR'S SIGNATURE <i>John Andrew P...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

item#3 file g733 3/11/96 ag per. doctor

96 06829

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NANCY COATES SMITH		2. DATE OF DEATH MONTH DAY YEAR December 12, 1995		3. TIME OF DEATH 2:35 a.m.	
4. SOCIAL SECURITY NUMBER 217-48-1492		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 45 YRS.	
7. DATE OF BIRTH (Month, Day, Year) May 29, 1950		8. BIRTHPLACE (State or Foreign Country) New Jersey			
9. FACILITY NAME (If not institution, give street and number) 406 Streamside Drive		10. CITY, TOWN OR LOCATION OF DEATH Fallston		11. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT					
12a. STATE Maryland		12b. COUNTY Harford		12c. CITY, TOWN OR LOCATION Fallston	
12d. STREET AND NUMBER 406 Streamside Drive		12e. ZIP CODE 21047		12f. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		14. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
16. OCCIDENT'S USUAL OCCUPATION (Specify any highest grade completed) 12th grade		17. OCCIDENT'S USUAL OCCUPATION (Specify any highest grade completed) 1 year		18. KIND OF BUSINESS/INDUSTRY Artist	
19. FATHER'S NAME (First, Middle, Last) Roger Mahlon Coates		20. MOTHER'S NAME (First, Middle, Maiden Surname) Margery Kelly			
21. INFORMANT'S NAME (Type, relationship) David H. Sliney (companion)		22. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 406 Streamside Drive-Fallston, Maryland 21047			
23a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Burial from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		23b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		23c. LOCATION — City or Town, State	
24. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir.		25. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559			
26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Carcinoma					Approximate Interval Between Onset and Death 6 years
Subsequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
27. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		30a. DATE OF INJURY (Month, Day, Year)		30b. TIME OF INJURY	
30c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		30d. DESCRIBE HOW INJURY OCCURRED		30e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
31. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated.					
32. SIGNATURE AND TITLE OF CERTIFIER Thomball G. Lurie		33. LICENSE NUMBER D17873		34. DATE SIGNED (Month, Day, Year) 1/26/96	
35. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4000 Old Court Rd. Suite 306 Baltimore, MD 21208					
36. DATE FILED (Month, Day, Year) MAR 11 1996		37. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 5 should be retained for use as the burial/cremation permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is missing, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
MAR 15 1996

VOID

CERTIFICATE 

96-06829

NANCY C. SMITH (95)

SEE

CERTIFICATE 

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES E TAYLOR

2. Date of Death
Month Day Year

3 4 96

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

CITY

Funeral
Director

5. Social Security Number

215-14-9700

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 17, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

915 N. Carrollton Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

unknown
1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

unknown
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor
unknown

16b. Kind of Business/Industry

Laundromat
unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown Ivanna (Mn -Unknown)

19a. Informant's Name/Relationship (Type, Print)

Terry Rogers (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

930 Amity Street-Baltimore, Maryland 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

3-11-96

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Ronald S. Wade, Dir.
3/12/96

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street
Rm. B026-Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin M. Zitrav MD

29c. License number

6853

29d. Date signed (Month, Day, Year)

3/4/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin Zitrav MD

31. Date filed (Month, Day, Year)

MAR 11 1996

State Registrar Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

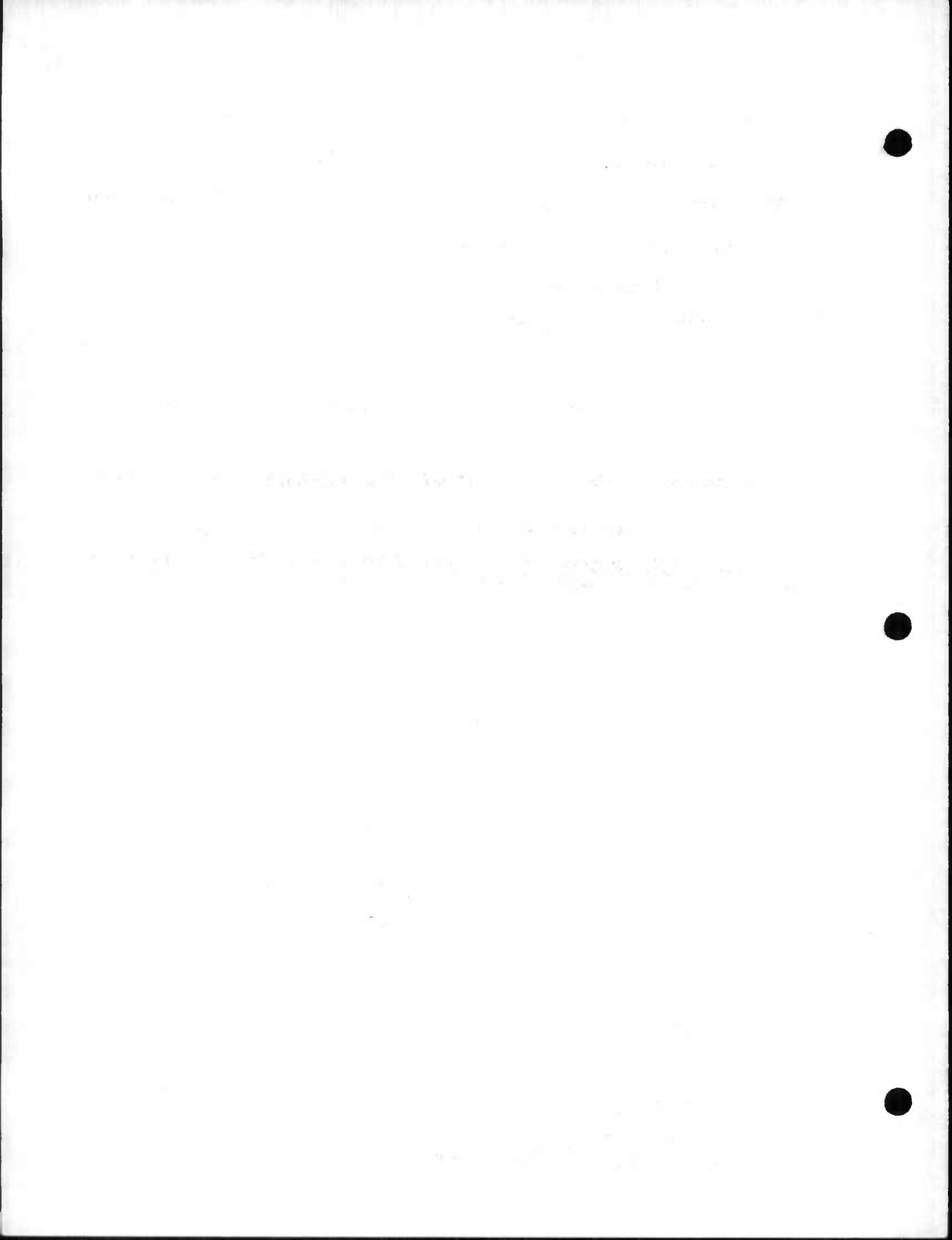
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

2

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06831

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERNESTINE A. VANN				2. Date of Death Month Day Year March 5 1996		3. Time of Death 10:44AM	
	4a. Facility Name (If not institution, give street and number) Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-34-3432		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) March 17, 1935	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 3031 Rosalind Avenue				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Piston Ring Inspector		16b. Kind of Business/Industry Kaydon Airline Parts			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Daniel Paige				18. Mother's Name (First, Middle, Maiden Surname) Margaret Wells			
	19a. Informant's Name/Relationship (Type, Print) James P. Vann				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Holshire Court Owings Mills, MD 21133			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet		Date 3/8/96	20c. Location - City or Town, State Owings Mills, MD		
	21. Signature of Funeral Service Licensee John March		22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Balto, MD 21215					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)							
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	a. Metabolic Acidosis Due to (or as a consequence of): b. Acute Renal Failure Due to (or as a consequence of): c. Severe Burn Injury Due to (or as a consequence of): d. Hepatorenal Syndrome							2 days 11 days 2 days Months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 1-29-96		28b. Time of Injury 11:30P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred House fire
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3032 Rosalind Ave						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Chita M. Fisher MD				29c. License number N1281		29d. Date signed (Month, Day, Year) March 5, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christian M. Fisher JHMC 4940 Eastern Ave. Baltimore, MD 21224								
31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature John March						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06832

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ralph Vardy				2. DATE OF DEATH MONTH DAY YEAR March 8 1996		3. TIME OF DEATH 11:20 P M	
4. SOCIAL SECURITY NUMBER 212-40-7085		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04 26 26	
8. BIRTHPLACE (State or Foreign Country) ENGLAND				9. COUNTY OF DEATH N/A			
10a. STATE MD.				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION DUNDALK	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 101 CENTRE PLACE APT 311			
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHAUFFEUR		16b. KIND OF BUSINESS/INDUSTRY TRUCKING			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN VARDY				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) MARIE E. VARDY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 CENTRE PLACE APT. 311 DUNDALK, MD. 21222			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEMETERY 3-12-96		20c. LOCATION — City or Town, State EASTWOOD, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles D. Zale				22. NAME AND ADDRESS OF FACILITY CHARLES S. ZEILERTSON INC. 6224 EASTWOOD AVE. BALTO-MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Todd Baldern M.D.		29c. LICENSE NUMBER 96000		29d. DATE SIGNED (Month, Day, Year) 3/9/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) MAR 11 1996				32. REGISTRAR'S SIGNATURE Jane [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Filmg, 733, item #1, 3/11/96, cyw, per fh

Certificate of Death

Reg. No.

96 06833

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROY RUAL J. WILLIAMS					2. Date of Death MARCH 05, 1996		3. Time of Death 2:45 PM.		
	4a. Facility Name (If not institution, give street and number) 3328 BURLIETH AVE.					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 237-30-3779		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 1, 1916		9. Birthplace (State or Foreign Country) N. Carolina	
	Usual Residence of Decedent									
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3328 Burleith Avenue					10f. Zip Code 21215		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Collage (1-4or 5+) Collage					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Steel Plant		
17. Father's Name (First, Middle, Last) Jessie Williams					18. Mother's Name (First, Middle, Maiden Surname) Lula Mayo					
19a. Informant's Name/Relationship (Type, Print) Donna Brummell-daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 660 Old Shool Rd., Clarksville, VA 23927					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 3/12		20c. Location - City or Town, State Randallstown, MD			
21. Signature of Funeral Service Licensee <i>Geroy O. Dyett</i>					22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE BALTO. 21207					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Blunt Force Trauma</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) 3-5-96		28b. Time of Injury UNK M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Subject beaten</i>	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Home</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>3328 Burleith Ave.</i>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>John Locke MD</i>			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 06, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) MAR 11 1996			32. Registrar's Signature <i>Julia Davidson Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06834

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lottie Williams				2. Date of Death Month March Day 2 Year 1996				3. Time of Death 2:11 PM						
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City				4c. County of Death Baltimore City						
Funeral Director	5. Social Security Number 214-20-1708		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth Month Sept. Day 13 Year 1924		9. Birthplace (State or Foreign Country) VIRGINIA						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 301 McMECHAN ST.				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIETICIAN			16b. Kind of Business/Industry NURSING HOME							
	17. Father's Name (First, Middle, Last) JOSEPH STOKES				18. Mother's Name (First, Middle, Maiden Surname) LILLIE MEEKS										
	19e. Informant's Name/Relationship (Type, Print) CAROLYN CARTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SIERRA CIRCLE OWINGS MILLS MD 21117										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State BALTIMORE MD								
	21. Signature of Funeral Service Licensee 				22. Name and Address of Funeral Home CARY LYNARCH FUNERAL HOME PA 270 FREDHILTON PASS BALTIMORE MD 21229										
	23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Cardiopulmonary Arrest Due to (or as a consequence of): Anoxic</td> <td rowspan="4"> Approximate Interval Between Onset and Death </td> </tr> <tr> <td>b. Encephalopathy Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardiopulmonary Arrest Due to (or as a consequence of): Anoxic	Approximate Interval Between Onset and Death	b. Encephalopathy Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardiopulmonary Arrest Due to (or as a consequence of): Anoxic	Approximate Interval Between Onset and Death													
	b. Encephalopathy Due to (or as a consequence of):														
	c. Due to (or as a consequence of):														
	d. Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 89262		29d. Date signed (Month, Day, Year) March 2, 1996									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savitha Nukal, M.D. c/o Maryland General Hospital															
31. Date filed (Month, Day, Year) MAR 11 1996															
32. Registrar's Signature 															

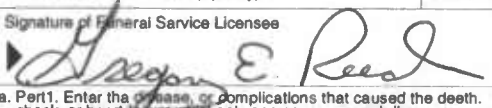

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

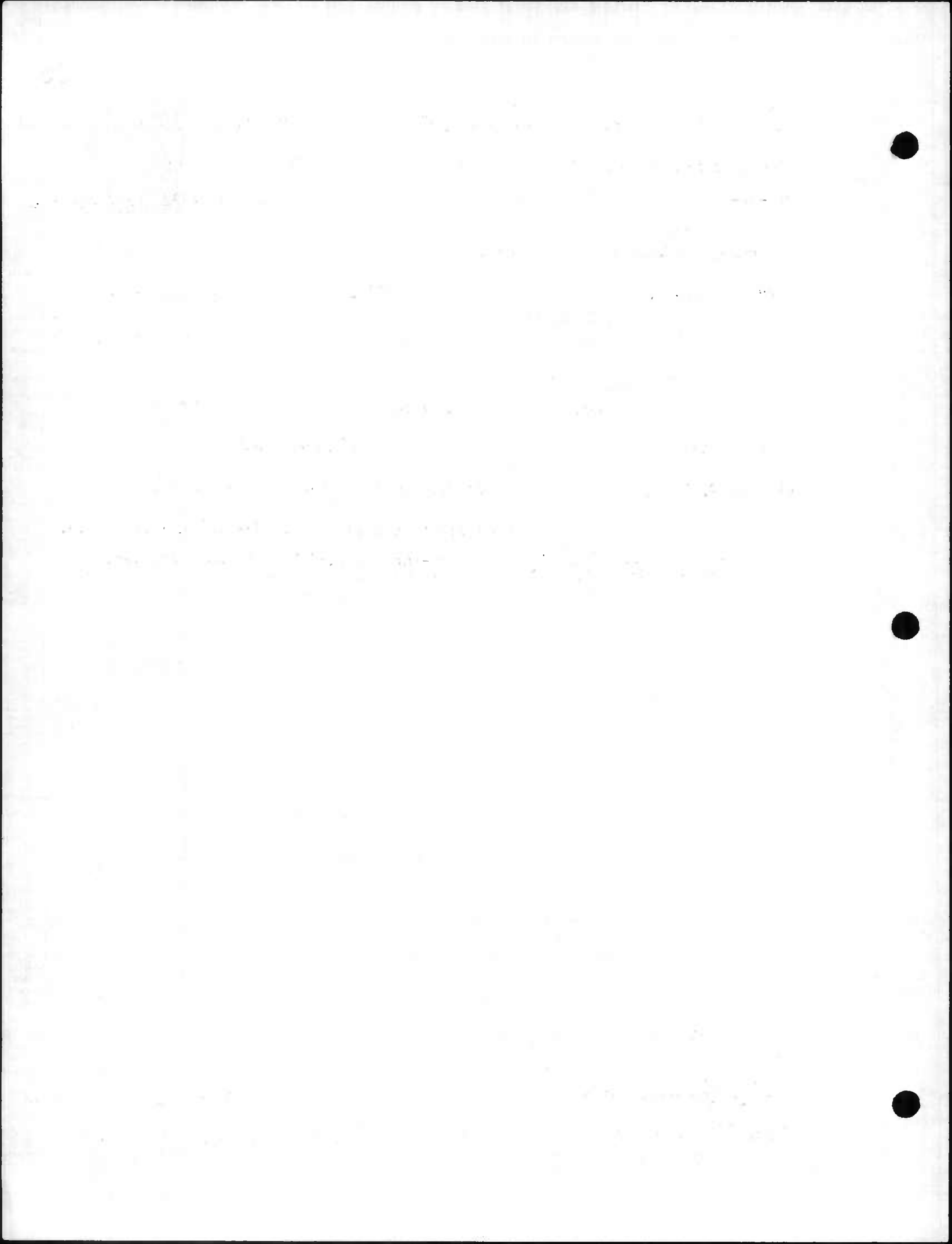
96 06835

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dolores Erma Wehner				2. Date of Death Month March Day seventh Year ninety six		3. Time of Death Five P.M.		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 216-30-0541		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) July 14, 1932		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 807 Wise Avenue		10f. Zip Code 21222		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian		16b. Kind of Business/Industry Government					
17. Father's Name (First, Middle, Last) Burtude Rexrode				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Burgess					
19a. Informant's Name/Relationship (Type, Print) Charles R. Wehner				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Wise Avenue Dundalk, Maryland 21222					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lahmansville Cemetery		20c. Date 3/11/96		20d. Location - City or Town, State Lahmansville, W.V.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222					
23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Fungal Sepsis Due to (or as a consequence of): b. Acute Respiratory Distress Syndrome Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		Approximate interval Between Onset and Death 3 days 2 weeks							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		28. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Tory Prestera MD		29c. License number P09897		29d. Date signed (Month, Day, Year) March seventh ninety six			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TORY PRESTERA M.D. Johns Hopkins Bayview medical center		31. Date filed (Month, Day, Year) MAR 11 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 06836

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hilda E. Watson				2. Date of Death Month February Day 26 , Year 1996				3. Time of Death 10:55 PM			
	4a. Facility Name (If not institution, give street and number) 701 North Arlington Avenue Apt 603				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a			
Funeral Director	5. Social Security Number 217-09-9069		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Sept 2, 1917		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent				10a. State Maryland				10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10a. Street and Number 701 North Arlington Avenue Apt 603				10f. Zip Code 21217				10g. Citizen of What Country? USA			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian				16b. Kind of Business/Industry Baltimore City Schools			
	17. Father's Name (First, Middle, Last) James Lake				18. Mother's Name (First, Middle, Maiden Surname) Daisy Spencer							
	19a. Informant's Name/Relationship (Type, Print) Wanda Watson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4810 Old York Road Baltimore, Maryland 21212							
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park				20c. Location - City or Town, State March 2 Baltimore County, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Nutter Funeral Homes Inc.				2501 Gwynn Falls PKY Baltimore, Maryland 21216			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. GI BLEEDING Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				24a. Was an autopsy performed? 1 Yes 2 No			
	25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day Year) March 2				28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28b. Location (Street and Number or Rural Route Number, City or Town, State)								
Physician /Medical Examiner	29a. Certifier (Check only one) 1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D27730		29d. Date signed (Month, Day, Year) 3/8/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY COHEN, MD. 6569 N. CHARLES ST. BALTIMORE MD 21204											
	31. Date filed (Month, Day, Year) MAR 11 1996				32. Registrar's Signature 							

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY DELORES WEBSTER				2. DATE OF DEATH MONTH MARCH DAY 6 YEAR 1996				3. TIME OF DEATH 0236A.M					
4. SOCIAL SECURITY NUMBER 216-30-2449		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 MRS. HOURS MIN. 		7. DATE OF BIRTH (Month, Day, Year) May 30, 1930		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) DEATON NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH N/A					
10a. STATE MARYLAND				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 611 S. CHARLES STREET				10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? USA,					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X				14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 6+H GRADE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC				16b. KIND OF BUSINESS/INDUSTRY PRIVATE HOMES					
17. FATHER'S NAME (First, Middle, Last) CHARLES WEBSTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA IRENE (MN-UNKNOWN)									
19a. INFORMANT'S NAME (Type/Print) CASCALIA BURRIS				19b. MAILING ADDRESS Chesterfield Ave 3027 E. CHESTERVILLE AVE, BALTIMORE, MD. 21213									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY 3-12-96 CATONSVILLE, MD.				DATE 		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. 										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, HYPERTENSION, PULMONARY EMBOLUS										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Brian C. Wallace MD				29c. LICENSE NUMBER D31136				29d. DATE SIGNED (Month, Day, Year) MAR 6, 1996					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN C. WALLACE, MD, 611 S. CHARLES ST., BALTIMORE, MD 21230													
31. DATE FILED (Month, Day, Year) MAR 11 1996													

DMMH-16 Rev 1/89

2

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06838

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Doyle		2. Date of Death Month February Day 23 Year 1996		3. Time of Death 1313
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert
Funeral Director	5. Social Security Number 579 10 2857	6. Sex 1 M 2 F	7. Age (in yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) December 9 1919	9. Birthplace (State or Foreign Country) Delaware
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location Lusby		10d. Inside City Limits 1 Yes 2 No
	10e. Street and Number 12974 Pine Place		10f. Zip Code 20657		10g. Citizen of What Country? United States
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates 41-79		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self employed/developer		16b. Kind of Business/Industry Housing		
	17. Father's Name (First, Middle, Last) William E. Booth		18. Mother's Name (First, Middle, Maiden Surname) Mary Grace Halsey		
	19a. Informant's Name/Relationship (Type, Print) Martha S. Booth		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12974 Pine Place Lusby, Maryland 20657		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service		20c. Location - City or Town, State February 25 1996 Alexandria Virginia
	21. Signature of Funeral Service Licensee B. Rausch		22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Maryland		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Failure Due to (or as a consequence of): b. Pneumonia Fibrosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary artery Disease - old Myocardial Infarction Dilated cardiomyopathy				
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
24a. Was an autopsy performed? 1 Yes 2 No					
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery Disease - old Myocardial Infarction Dilated cardiomyopathy				
	25. Was case referred to medical examiner? 1 Yes 2 No				
	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)				
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 8 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) M		
	28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier AT Mundy M.D. Alameda Physic.		29c. License number D 194 27		29d. Date signed (Month, Day, Year) 2/25/96
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)				
	State Registrar	31. Date filed (Month, Day, Year) FEB 27 1996		32. Registrar's Signature J. Dawson-Randall	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

96 06839

1. DECEDENT'S NAME (First, Middle, Last) Janice Brienza				2. DATE OF DEATH February 17, 1996 YEAR MONTH DAY		3. TIME OF DEATH 4:00 p M					
4. SOCIAL SECURITY NUMBER 120 46 0845		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 22, 1952		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) 3024 G, Orangeman Square				9b. CITY, TOWN OR LOCATION OF DEATH Waldorf			9c. COUNTY OF DEATH Charles				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Waldorf			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3024 G, Orangeman Square		10f. ZIP CODE 20603		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) hairdresser		16b. KIND OF BUSINESS/INDUSTRY cosmetology							
17. FATHER'S NAME (First, Middle, Last) Anthony Collica				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Calaprisco							
19a. INFORMANT'S NAME (Type/Print) Charles J. Brienza / spouse				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Fairway Drive, Dunedin, FL 34698							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 2/24/96		20c. LOCATION — City or Town, State Alexandria, VA							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, P.A., Owings, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Drug Overdose DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death Minutes			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 2/7/96		28b. TIME OF INJURY 3:01 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED Acc. fatal drug overdose			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3024 G Orangeman Sq. Waldorf							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER  Charles C. Smith M.D.				29c. LICENSE NUMBER D27348		29d. DATE SIGNED (Month, Day, Year) 2/19/96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard Haft, MD 700 Old Line Center Suite #100 Waldorf, MD 20602											
31. DATE FILED (Month, Day, Year) FEB 27 1996				32. REGISTRAR'S SIGNATURE 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06840

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACK ROLAND BILLMAN

2. Date of Death

Month Day Year
FEBRUARY 27, 1996

3. Time of Death

5:35 p

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

5. Social Security Number

219-20-1009

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 4, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

633 Highland Way

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1948-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

railroad

17. Father's Name (First, Middle, Last)

Chester Billman

18. Mother's Name (First, Middle, Maiden Surname)

Frances McCleary

19a. Informant's Name/Relationship (Type, Print)

Katherine Holland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

633 Highland Way, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery 3-1-96

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Immunosuppression

Due to (or as a consequence of):

16 months

c. Lung Transplant

Due to (or as a consequence of):

16 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Medical Resident

29c. License number

J 8265

29d. Date signed (Month, Day, Year)

February 27, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lisa Lehman 600 North Wolf Street Baltimore, Maryland 21205

31. Date filed (Month, Day, Year)

MAR -1 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

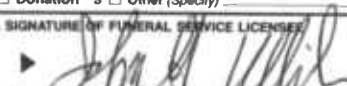
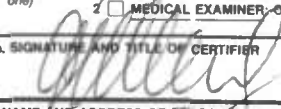

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

96 06841

1. DECEDENT'S NAME (First, Middle, Last) LEWIS R. BRAHIN				2. DATE OF DEATH MONTH 2 DAY 20 YEAR 96		3. TIME OF DEATH 8:30 PM			
4. SOCIAL SECURITY NUMBER 224-14-6643		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-15-16		8. BIRTHPLACE (State or Foreign Country) PA.	
9a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BERLIN			9c. COUNTY OF DEATH WORCESTER		
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 59 ANCHOR WAY				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1933		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONDUCTOR			16b. KIND OF BUSINESS/INDUSTRY RAILROAD				
17. FATHER'S NAME (First, Middle, Last) RUBIN BRAHIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNIE SEGAL					
19a. INFORMANT'S NAME (Type/Print) DOROTHY E. BRAHIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 ANCHOR WAY BERLIN, MD., 21811					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK 2-24		20c. LOCATION — City or Town, State BERLIN, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular arrhythmias Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Acute massive myocardial infarct CORONARY ARTERY DISEASE								Approximate Interval Between Onset and Death < 1 hr 2 1/2 hr > 5 yr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER D42083		29d. DATE SIGNED (Month, Day, Year) 2-21-96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Greta A. Hester, 9733 Heathway Drive BERLIN MD									
31. DATE FILED (Month, Day, Year) FEB 22 1996			32. REGISTRAR'S SIGNATURE 						

96 06842

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marilyn Hudson Barton				2. DATE OF DEATH MONTH DAY YEAR February 20, 1996		3. TIME OF DEATH 12:50 A M	
4. SOCIAL SECURITY NUMBER 220-07-0179		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/8/18	
9a. FACILITY NAME (If not institution, give street and number) 10508 Amherst Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD				10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Ocean City	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 6 Surf Ave.				10f. ZIP CODE 21842		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Secretary		16b. KIND OF BUSINESS/INDUSTRY Communications	
17. FATHER'S NAME (First, Middle, Last) Charles Hudson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marilyn Nell Robbins			
19a. INFORMANT'S NAME (Type/Print) Marilyn James				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10508 Amherst Ave. Silver Spring, MD 20902			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cape Henlopen Crematory 2/21/96		20c. LOCATION — City or Town, State Frankford, DE			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. J. Burdette</i>				22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 21811			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): a. Lung Cancer b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 6 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas L. Sacks</i>				29c. LICENSE NUMBER DC 12568		29d. DATE SIGNED (Month, Day, Year) 2/20/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas L. Sacks, MD 2021 K Street, NW #516 Washington, DC 20006							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5400

1



Amended line 1, JLD, FCHD as Per Funeral Director
8,18 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06843

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BRIZZI HANDSCHUH, Elizabeth B. Handschuh				2. Date of Death Month Day Year 2 - 15 - 96		3. Time of Death 2000
	4a. Facility Name (If not Institution, give street and number) Carroll County General Hosp				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL
Funeral Director	5. Social Security Number 142-24-8750	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06/28/31	
	9. Birthplace (State or Foreign Country) New Jersey						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State MD	10b. County Carroll	10c. City, Town or Location Mt Airy			10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 4054 Boteler Rd			10f. Zip Code 21771		10g. Citizen of What Country? United States	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Financial Industry		
	17. Father's Name (First, Middle, Last) NAPOLIONE				18. Mother's Name (First, Middle, Maiden Surname) BRIZZI GUISEPPE CONTI		
	19a. Informant's Name/Relationship (Type, Print) JOANNE MEACHAM (dght.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4054 Boteler Rd./ Mt. Airy, Maryland 21771		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		Date 2-20-96	20c. Location - City or Town, State Mt. Airy, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Home 8 E. Ridgeville Blvd./ Mt. Airy, Maryland 21771		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Accident Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
Approximate Interval Between Onset and Death 1 day							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
							24e. Was an autopsy performed? 1 Yes 2 No
							24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	25. Was case referred to medical examiner? 1 Yes 2 No						
	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 				29c. License number 024321		29d. Date signed (Month, Day, Year) 2/16/96
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philp Kinto						
State Registrar	31. Date filed (Month, Day, Year) FEB 28 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 06844

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FERRIS DOTRIDGE BRAWNER				2. DATE OF DEATH MONTH 2 DAY 12 YEAR 96		3. TIME OF DEATH 6:00 P.M.	
4. SOCIAL SECURITY NUMBER 721-16-9398		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/23/1925	
8. BIRTHPLACE (State or Foreign Country) Brunswick MD				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Knoxville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 206 Jefferson Pike	
10f. ZIP CODE 21758				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor				16b. KIND OF BUSINESS/INDUSTRY National Bureau of Standards			
17. FATHER'S NAME (First, Middle, Last) Fennis Dotridge Brawner, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen S. Cannon			
19a. INFORMANT'S NAME (Type/Print) George F. Brawner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Knoxville Rd., Knoxville, MD 21758			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Park Heights Cemetery			
20c. LOCATION — City or Town, State Brunswick, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara A. Williams, Owner			
22. NAME AND ADDRESS OF FACILITY John T. Williams Funeral Home 100 Petersville Rd., Brunswick, MD				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Robert R. Roberts MD			
29c. LICENSE NUMBER D09867				29d. DATE SIGNED (Month, Day, Year) 2/12/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RRRR Roberts MD 52 Thomas Johnson Dr Frederick Md 21702							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE Julia D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06845

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marian Luvenia Bowie

2. Date of Death

Month Day Year
February 11, 1996

3. Time of Death

12:52 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-16-1405

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 29, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1000-A Heather Ridge Dr.
1000 Country Hill Apts.

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond M. West

18. Mother's Name (First, Middle, Maiden Surname)

Vivian Etta Brown

19a. Informant's Name/Relationship (Type, Print)

Margaret Foreman (dght.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2129 Wainwright Ct./ Frederick, Md. 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resthaven Memorial

Date

2/15

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home
1621 Opossumtown Pike/ Frederick, Md. 2170223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Left Lingular Pneumonia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

days

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic malabsorption

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D35553

29d. Date signed (Month, Day, Year)

2/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. P. Henry 610 9th Ave. Brunswick, MD 21716

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06846

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN FRANCES BLAKE

2. Date of Death

FEB

Day

7

Year

96

3. Time of Death

0704

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

220-28-2135

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 22, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 Frederick Rd.

10f. Zip Code

21788

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Collator Operator

16b. Kind of Business/Industry

Business Forms

17. Father's Name (First, Middle, Last)

Morris C. Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn F. Brubaker

19a. Informant's Name/Relationship (Type, Print)

Jack R. Blake

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Frederick Rd., Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Blue Ridge Cemetery

Date

2/10

20c. Location - City or Town, State

Thurmont, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Dailey & Son Funeral Homes, P.A.

615 E. Main St., Thurmont, MD 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. MULTI-SYSTEM ORGAN FAILURE

Due to (or as a consequence of):

b. SEPTIC SHOCK

Due to (or as a consequence of):

c. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, HTN, DM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

D46536

29d. Date signed (Month, Day, Year)

FEB 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22.S.GREENE ST. BALTIMORE, MD #21201

31. Date filed (Month, Day, Year)

FEB 12 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

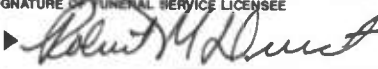
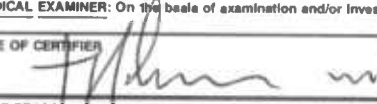

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHLEEN HELEN BROWNING				2. DATE OF DEATH MONTH FEBRUARY DAY 18 YEAR 1996				3. TIME OF DEATH 9:40 A M			
4. SOCIAL SECURITY NUMBER 214-74-5968		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) MAY 25, 1919		8. BIRTHPLACE (State or Foreign Country) WV			
9a. FACILITY NAME (If not institution, give street and number) CUPPETT & WEEKS NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND				9c. COUNTY OF DEATH GARRETT			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION OAKLAND				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 210 W. PENNINGTON STREET				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 10			College (1-4 or 5+) College (1-4 or 5+)			HOMEMAKER			OWN HOME		
17. FATHER'S NAME (First, Middle, Last) CHARLES EDGAR MARKWOOD					18. MOTHER'S NAME (First, Middle, Maiden Surname) ODA MABEL ROTH						
19a. INFORMANT'S NAME (Type/Print) ED BROWNING			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 206 McHENRY, MD 21541								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRETT EMEORIAL GARDENS		DATE 2/20	20c. LOCATION — City or Town, State OAKLAND, MARYLAND					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0167			22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME -- OAKLAND, MD 21550								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA Due to (or as a consequence of): cerebro vascular insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death 10 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic schizophrenia chronic bronchitis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER D15333		29d. DATE SIGNED (Month, Day, Year) 2/19/96				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas G. Johnson, M.D., 311 N. Fourth Street Oakland, MD 21550											
31. DATE FILED (Month, Day, Year) FEB 20 1996		32. REGISTRAR'S SIGNATURE 									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06848

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERNON R. BROADWATER				2. Date of Death Month FEBRUARY Day 23 Year 1996		3. Time of Death 12:50 PM		
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 213-24-7130		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 20 1929	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Germantown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 2040 Frederick Road				10f. Zip Code 20874		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Travel Agent		16b. Kind of Business/Industry Travel		
	17. Father's Name (First, Middle, Last) Reuben Broadwater				18. Mother's Name (First, Middle, Maiden Summa) Florence Ethel Broadwater				
	19a. Informant's Name/Relationship (Type, Print) Eldred Broadwater				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18601 Takoma Dr. Barton, Md. 21521				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery		Date 2-25-96		20c. Location - City or Town, State Westernport, Md.		
	21. Signature of Funeral Service Licensee Wayne Boal				22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of): b. CHF Due to (or as a consequence of): c. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): d. CORONARY ARTERY DISEASE								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSULIN DEPENDENT DIABETES MELLITUS Renal insufficiency Anemia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Felix Sokolsky		29c. License number D 46364		29d. Date signed (Month, Day, Year) 02-23-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FELIX SOKOLSKY 6111 EXECUTIVE BLVD, ROCKVILLE, MD, 20852									
31. Date filed (Month, Day, Year) FEB 27 1996				32. Registrar's Signature Felix Sokolsky					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06849

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jabez F. Brown

Jabez Fisher Brown SR

2. Date of Death

Month
02Day
22Year
96

3. Time of Death

11:45

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

213-30-6517

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 5 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Annes

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No
X

10e. Street and Number

P.O. Box 154

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Livestock Dealer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Eugene F. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Laura Quimby Brown

19a. Informant's Name/Relationship (Type, Print)

Betty Thompson Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 154 Centreville, Maryland 21617

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Church Hill Cemetery

Date

2/26/96

20c. Location - City or Town, State

Church Hill, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein, and Newnam Funeral Home
130 Speer Road Chestertown, Maryland 2162023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Acute Respiratory Failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Clinical brain death
Due to (or as a consequence of):

2 Days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

P09729

29d. Date signed (Month, Day, Year)

02-22-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 26 '96

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06850

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Hurd Breul

2. Date of Death
Month Day Year

February 24, 1996

3. Time of Death

9:10 am

4a. Facility Name (If not institution, give street and number)

Heron Point, 501 Campus Avenue

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

512-40-3170

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 26, 1924

9. Birthplace (State or Foreign Country)

Bridgeport, Conn

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

326 Heron Point

10f. Zip Code

21620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Episcopal Priest & Publisher Religion

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Alvin Chester Breul

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Remnell

19a. Informant's Name/Relationship (Type, Print)

Mildred Breul

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

326 Heron Point, Chestertown, Maryland 21620

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory/February 29, 1996

Data

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

William L. King, Jr.

22. Name and Address of Facility

Fellows, Helfenbein, & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

2 mo.

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

2mo.

Due to (or as a consequence of):

c. CORONARY ATHEROSCLEROSIS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Helen A. Noble MD

29c. License number

D 41587

29d. Date signed (Month, Day, Year)

2/27/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble MD, Speer Rd, Chestertown, Md 21620

31. Date filed (Month, Day, Year)

FEB 27 '96

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

2.3. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.4. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.5. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.6. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.7. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.8. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.9. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.10. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

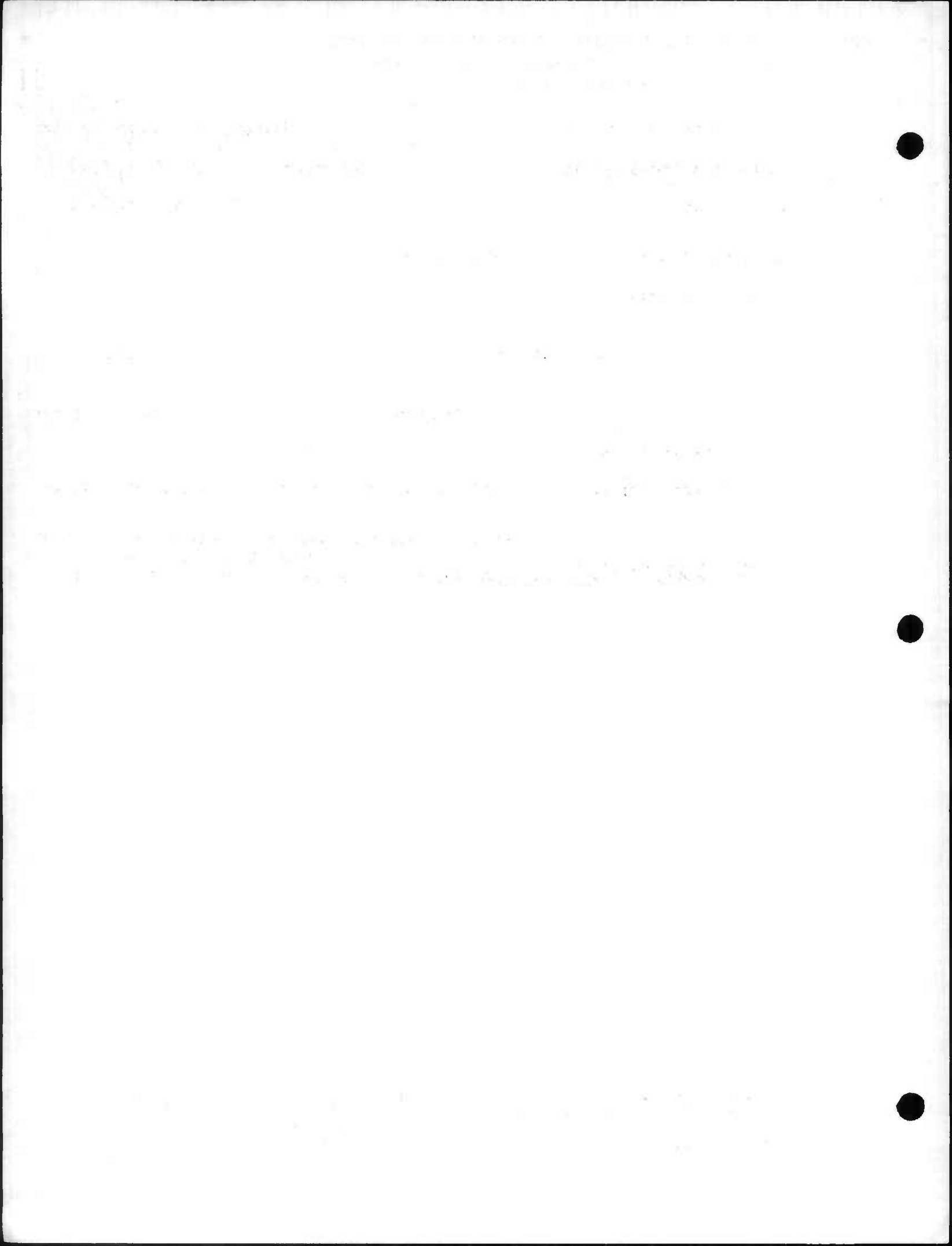
2.11. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.12. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

2.13. $\frac{1}{2} \pi$ phase shift
The phase shift is $\frac{1}{2} \pi$ for the $\frac{1}{2} \pi$ phase shift.

96 06851

DHHM 16 Rev 6/95



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 06852			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
IVA BLANCHE COATS				February 13, 1996				11:05 P.M.			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
214-36-6726		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		95 YRS.		March 5, 1900		West Virginia			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Meridian Nursing Home				Frederick				Frederick			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Maryland		Frederick		Frederick		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10a. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
1421 Taney Ave.				21702				United States			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 3 College (1-4 or 5+) —				Homemaker				Own Home			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
GEORGE WILSON				ELIZABETH WOLFORD							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
LOWELL COATS				7513 Mountain Approach Rd./ Adamstown, Md. 21710							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Resthaven memorial gardens 2/17		Frederick, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
<i>Raymond Peterson</i>				STAUFFER FUNERAL HOME 1621 Opossumtown pike/ Frederick, Md. 21702							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA											
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
a. DUE TO (OR AS A CONSEQUENCE OF): ASCVD											
b. DUE TO (OR AS A CONSEQUENCE OF): A. fibrillation											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				117549				Feb. 14, 1996			
29b. SIGNATURE AND TITLE OF CERTIFIER											
Dr. William F. Harper / 100 S. Center St./ Thurmont, Md. 21788											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
FEB 21 1996				<i>John Harrison Randall</i>							

96 06853

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sister Mary Paul Chrismer				2. DATE OF DEATH MONTH 2-12-96 DAY YEAR		3. TIME OF DEATH 12:15 am M	
4. SOCIAL SECURITY NUMBER 022-40-0529		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 5, 1911	
9a. FACILITY NAME (If not institution, give street and number) Villa St. Michael				9b. CITY, TOWN OR LOCATION OF DEATH Emmitsburg		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Emmitsburg	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 333 South Seton Avenue			
10f. ZIP CODE 21727				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College 4+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		16b. KIND OF BUSINESS/INDUSTRY Religious Community Daughters of Charity			
17. FATHER'S NAME (First, Middle, Last) Edwin Chrismer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeanette Agnes Humerick			
19a. INFORMANT'S NAME (Type/Print) Sister Camilla Harant				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. Seton Ave., Emmitsburg, MD 21727			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. JOSEPH'S 2/14/96		20c. LOCATION — City or Town, State EMMITSBURG, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John M. Skiles				22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Heart Disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 wk 7-10 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease with Dementia Remote history of hypertension and stroke							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Alan Carroll M.D.				29c. LICENSE NUMBER S18705		29d. DATE SIGNED (Month, Day, Year) 2/12/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN CARROLL, M.D. 310 S. SETON AVE., EMMITSBURG, MD. 21727							
31. DATE FILED (Month, Day, Year) FEB 14 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06854

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LESLIE PAIGE CRAWFORD				2. DATE OF DEATH MONTH DAY YEAR February 11, 1996		3. TIME OF DEATH 8:30 p.m.	
4. SOCIAL SECURITY NUMBER 232-10-4811		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 29, 1910	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 311 West Seventh St.	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chemist		16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) TERRANCE L. CRAWFORD				18. MOTHER'S NAME (First, Middle, Maiden Surname) GATIE L. POWELL			
19a. INFORMANT'S NAME (Type/Print) MARIAN R. CRAWFORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 West Seventh St./ Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Peterson</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, Md. 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease 25 yrs SEE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial infarction A72, Chronic atrial fibrillation DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ali J. Afrookteh</i>				29c. LICENSE NUMBER D - 35183		29d. DATE SIGNED (Month, Day, Year) 2/13/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ali J. Afrookteh / 300 West Ninth St. / Frederick, Md. 21701							
31. DATE FILED (Month, Day, Year) FEB 16 1996				32. REGISTRAR'S SIGNATURE <i>Miss Thelma Randolph</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06855

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM B. CHEW				2. DATE OF DEATH MONTH February DAY 23 YEAR 1996		3. TIME OF DEATH 5:45 P. M.	
4. SOCIAL SECURITY NUMBER 216-20-3651		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 19, 1925	
9a. FACILITY NAME (If not institution, give street and number) McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield, MD		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5030 Annessex Road				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II- U.S. Navy		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate College (1-4 or 5+) 1 Year				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contract Estimator		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) William E. Chew				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth G. Clark			
19a. INFORMANT'S NAME (Type/Print) Lois M. Chew (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5030 Annessex Rd. - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens - 2/27/96		20c. LOCATION — City or Town, State Hebron, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James A. Sterling				29c. LICENSE NUMBER D-10214		29d. DATE SIGNED (Month, Day, Year) Feb. 26, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817							
31. DATE FILED (Month, Day, Year) FEB 27 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

67

John Smith 1943

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06856

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN Waters

COSNER

2. Date of Death

FEBRUARY 23 1996

3. Time of Death

9:45 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

863 W. LOMBARD STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore

5. Social Security Number

220-34-1533

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 12, 1937

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

834 West Lombard Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Calvin Martin Cosner

18. Mother's Name (First, Middle, Maiden Surname)

Onie Helen Aronhalt

19a. Informant's Name/Relationship (Type, Print)

Celia Tyszko, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4828 Hazelwood Ave., Baltimore, MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Locust Grove Cemetery

Date

2/26

20c. Location - City or Town, State

Mt. Storm, WV

21. Signature of Funeral Service Licensee

► *Broderick A. [Signature]*

22. Name and Address of Facility

Stewart Funeral Home
32 S. 2nd. St., Oakland, MD 2155023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Atherosclerotic Cardiovascular Heart Disease*Approximate
Interval Between
Onset and Death

Years

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *Margaret [Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marysara A. Korze 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 26 1996

32. Registrar's Signature

John [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR



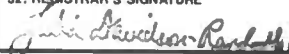
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) HELEN MABEL CAMPBELL								2. DATE OF DEATH MONTH DAY YEAR February 23, 1996				3. TIME OF DEATH 10:15 P.M.			
4. SOCIAL SECURITY NUMBER 215-26-0549				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 20, 1907		8. BIRTHPLACE (State or Foreign Country) Indiana	
9a. FACILITY NAME (If not institution, give street and number) 7074 Catalpa Road								9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick			
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY Frederick				10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 7074 Catalpa Road								10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own							
17. FATHER'S NAME (First, Middle, Last) Bernard J. Conroy								18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Logue							
19a. INFORMANT'S NAME (Type/Print) Guelda C. Imirie								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 East Third Street Frederick, Maryland 21701							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National 2/28/96				20c. LOCATION — City or Town, State Arlington, Virginia							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY Stauffer funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Adenocarcinoma of Gallbladder DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death 1 month			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Martha Pierce, MD								29c. LICENSE NUMBER D46248		29d. DATE SIGNED (Month, Day, Year) 2/26/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 40 Bayhman Lane, Frederick MD 21701 Martha Pierce															
31. DATE FILED (Month, Day, Year) FEB 27 1996				32. REGISTRAR'S SIGNATURE 											

96 06858

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alexander Harry Cotsonis				2. DATE OF DEATH MONTH DAY YEAR February 22 1996		3. TIME OF DEATH 7:55 A M	
4. SOCIAL SECURITY NUMBER 577-10-2943		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 25 1911	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 220 Kentland Blvd. #103			
10f. ZIP CODE 20878				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942/45		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil engineer		16b. KIND OF BUSINESS/INDUSTRY Engineer			
17. FATHER'S NAME (First, Middle, Last) Harry Cotsonis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Sohoss			
19a. INFORMANT'S NAME (Type/Print) Fr. J. Cotsonis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 152 Beallsville, MD 20839			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD National Mem. Park 12/24 Laurel, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home 22111 Beallsville Rd Barnesville, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Ventricular Fibrillation				Approximate Interval Between Onset and Death 16 minute	
		b. Myocardial Infarction				7 weeks	
		c. Atherosclerotic Cardiovascular Disease				years	
		d.					
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Quadrant Upper Bleed, Small Bowel Obstruction							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D31840		29d. DATE SIGNED (Month, Day, Year) February 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne L. Meyer, MD 9715 Medical Center Drive Suite 214, Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) FEB 28 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06859

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Joan Carrick				2. DATE OF DEATH MONTH DAY YEAR February 20, 1996		3. TIME OF DEATH 12:35 p.m.	
4. SOCIAL SECURITY NUMBER 138-26-5003		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 61 YRS.	7. DATE OF BIRTH (Month, Day, Year) September 28, 1934		8. BIRTHPLACE (State or Foreign Country) Atkins, Virginia	
9a. FACILITY NAME (If not institution, give street and number) Anundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anna Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Queen Annes		10c. CITY, TOWN OR LOCATION Queenstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3100 Bennett Point Road				10f. ZIP CODE 21658		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Domestic/Own Home			
17. FATHER'S NAME (First, Middle, Last) Maurice Henry Nichoson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Elinor Totten			
19a. INFORMANT'S NAME (Type/Print) E. Wayne Carrick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fords Landing Lane, Millington, MD 21651			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crumpton Cemetery/February 26, 1996		20c. LOCATION — City or Town, State Crumpton, Maryland		22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein, & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary B. Sellows</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic Adenocarcinoma of the Lung							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Brain metastasis of lung Carcinoma Smoking tobacco							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John P. Serlemitsos</i> MD				29c. LICENSE NUMBER D32654		29d. DATE SIGNED (Month, Day, Year) February 20, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John P. Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012							
31. DATE FILED (Month, Day, Year) FEB 23 '96		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06860

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl Evelyn

Davis

2. Date of Death
Month Day Year

February 21, 1996

3. Time of Death

15:00

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick Calvert

4c. County of Death

Funeral
Director

5. Social Security Number

577 16 2580

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 5 1919

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State
Maryland10b. County
Calvert10c. City, Town or Location
Lusby

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

468 Lake Drive

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

US Government

16b. Kind of Business/Industry

Dept. Agriculture

17. Father's Name (First, Middle, Last)

Percy D. Roach

18. Mother's Name (First, Middle, Maiden Surname)

Mae Belle Baldwin

19a. Informant's Name/Relationship (Type, Print)

Virginia M. Dougan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

468 Lake Drive Lusby, Maryland 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln February 26 1996

Data

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home 20676

4405 Broomes Island Road Port Republic Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Hypoxic encephalopathy
Due to (or as a consequence of):b. Respiratory failure
Due to (or as a consequence of):c. Advanced COPD
Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. M. Louke

29c. License number

D47598

29d. Date signed (Month, Day, Year)

2/22/16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. M. Shah 100 Hospital Rd. Prince Frederick, MD. 20678

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

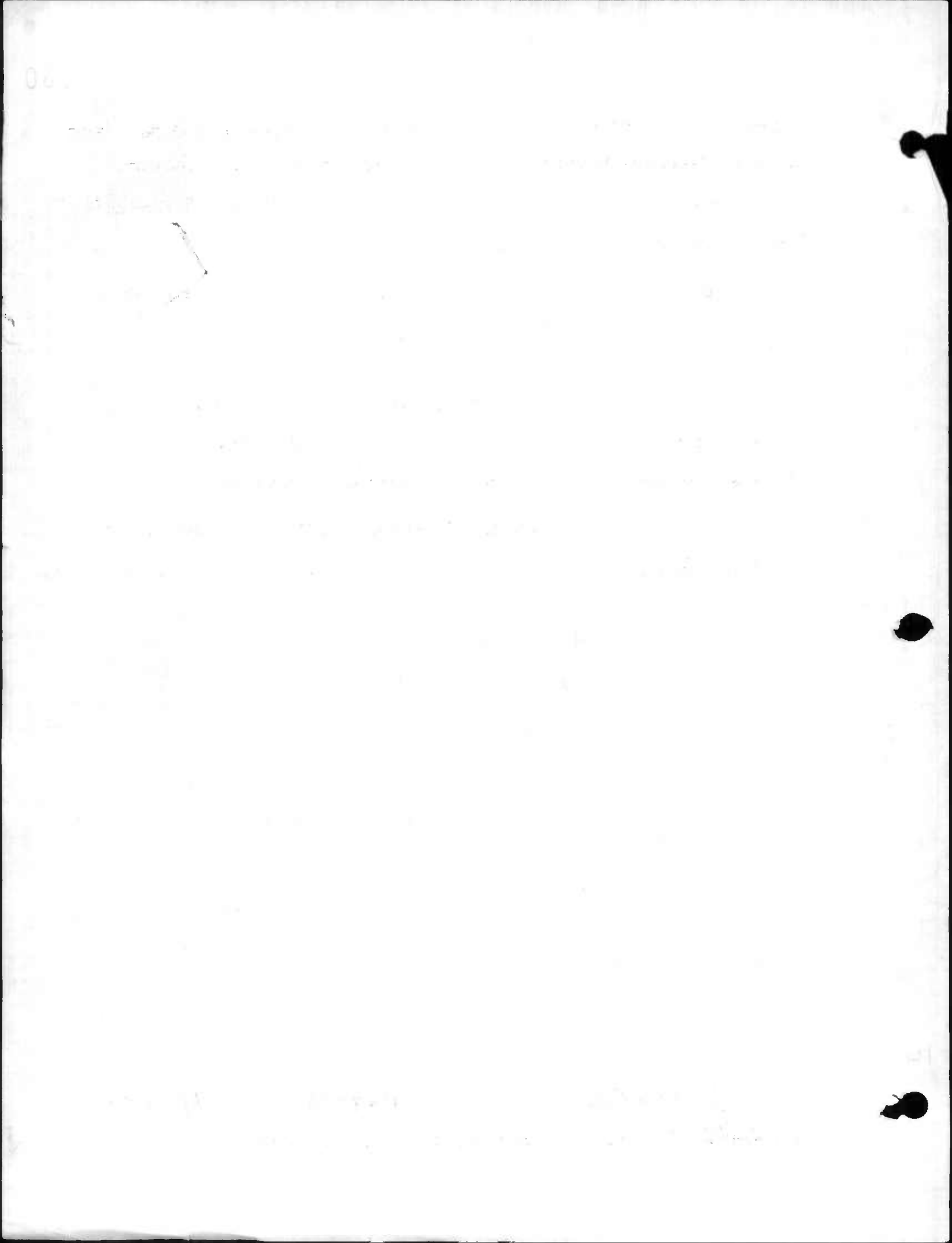
Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

96 06861

1. DECEDENT'S NAME (First, Middle, Last) HILDA DREW				2. DATE OF DEATH MONTH 2 DAY 25 YEAR 96		3. TIME OF DEATH 9 A M							
4. SOCIAL SECURITY NUMBER 230-52-5764		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-24-08		8. BIRTHPLACE (State or Foreign Country) Virginia					
9a. FACILITY NAME (If not institution, give street and number) Snow Hill Nursing & Rehab.Center				9b. CITY, TOWN OR LOCATION OF DEATH Snow Hill				9c. COUNTY OF DEATH Worcester					
10a. STATE Va.		10b. COUNTY Accomack		10c. CITY, TOWN OR LOCATION Saxis				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER P.O. Box 28				10f. ZIP CODE 23426		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) homemaker				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home							
17. FATHER'S NAME (First, Middle, Last) Charles G. Northam				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Johnson Northam									
19a. INFORMANT'S NAME (Type/Print) Claude W. Drew, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 South Drive, Snow Hill, Md. 21863									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Downing Cemetery		DATE 2/28		20c. LOCATION — City or Town, State Oak Hall, Va.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Patricia L. Dennis				22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home P.O. Box 87, Snow Hill, Md. 21863									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death MANY YEARS													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SENILE DEMENTIA, INANITION								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Dorothy C. Holzworth M.D.		29c. LICENSE NUMBER D06241		29d. DATE SIGNED (Month, Day, Year) 2-25-96							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DOROTHY C. HOLZWORTH 203 SNOW ST. SNOW HILL, MD. 21863													
31. DATE FILED (Month, Day, Year) FEB 26 1996				32. REGISTRAR'S SIGNATURE Jane Anderson-Randall									


Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06862

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID RAY DUDLEY				2. Date of Death Month Day Year FEB. 10, 1996		3. Time of Death 0635AM	
	4a. Facility Name (If not institution, give street and number) ROUTE#77 & TOWER ROAD				4b. City, Town, or Location of Death Thurmont		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 216-90-2464	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 28, 1973	9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7316 Lakeview Road				10f. Zip Code 21701		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinest		16b. Kind of Business/Industry Alexander Binzel Company		
17. Father's Name (First, Middle, Last) Ray W. Dudley				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth J. Jeffrey				
19a. Informant's Name/Relationship (Type, Print) Ray W. Dudley				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7316 Lakeview Road Frederick, Maryland 21701				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cemetery		Date 2/14/96		20c. Location - City or Town, State Artemus, Pennsylvania		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Due to (or as a consequence of): e. _____ Due to (or as a consequence of): f. _____ Due to (or as a consequence of): g. _____ Due to (or as a consequence of): h. _____								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 2-10-96		28b. Time of Injury 0603 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28d. Describe how Injury occurred Driver in auto accident				
28f. Location (Street and Number or Rural Route Number, City or Town, State) RT. 77 (EAST OF TOWER RD)								
29. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) FEBRUARY 10, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. A. Locke, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) FEB 12 1996				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06863

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

JEFFERY

JEROME DENNIS

2. Date of Death
Month Day Year

FEBRUARY 21 1996

3. Time of Death

11:00 AM

4a. Facility Name (If not institution, give street and number)

KENT AND QUEEN ANNE'S HOSPITAL

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT & QUEEN ANNE

5. Social Security Number

166-44-4286

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State
PA

10b. County

10c. City, Town or Location

DARBY

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

225 WRIGHT AVE.

10f. Zip Code

19023

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0-12

1-4 or 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life - DO NOT use retired)

DRIVER

16b. Kind of Business/Industry

TRUCK

17. Father's Name (First, Middle, Last)

HAROLD MILLER JR.

18. Mother's Name (First, Middle, Maiden Surname)

BEVERLY DENNIS MOTHER

19a. Informant's Name/Relationship (Type, Print)

BEVERLY DENNIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 WRIGHT AVE, DARBY PA, 1902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Collingdale Rd 29/96 Collingdale, PA

21. Signature of Funeral Service Licensee

Dennis J. Chute

22. Name and Address of Facility

WALTER FUNERAL HOME
CHESTERTOWN, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

2/21/96

28b. Time of Injury

9:45 AM

28c. Injury at Work?

1 ☒ Yes 2 ☐ No

28d. Describe how injury occurred:

tractor-trailer motor vehicle collision

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rt 301 + Rt 15
Queen Anne's Co, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 26 '96

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06864

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FANNY KATHRYN ENGLUND

2. Date of Death

Month Day Year
FEB. 22, 1996

3. Time of Death

9:45 A.M.

4a. Facility Name (If not institution, give street and number)

3313 HILTON DRIVE

4b. City, Town, or Location of Death

LEXINGTON PARK

4c. County of Death

ST. MARY'S

Funeral
Director

5. Social Security Number

103-07-1425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9-11-1916

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State
MARYLAND10b. County
ST. MARY'S

10c. City, Town or Location

LEXINGTON PARK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3313 HILTON DRIVE

10f. Zip Code

20653

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9TH GRADE

College (1-4 or 5+)

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHAN W. ABRAHAMSON

18. Mother's Name (First, Middle, Maiden Surname)

HILDA FRUGORD

19e. Informant's Name/Relationship (Type, Print)

NANCY BOOTH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2645 HIDDEN HILL CT. HUNTINGTOWN, MD. 20639

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

SOUTHERN MEM. GARDENS 2-24-96 DUNKIRK, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RAYMOND FUNERAL HOME
DUNKIRK, MARYLAND 20754

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)e. Severe pulmonary fibrosis
Due to (or as a consequence of):Approximate
interval Between
Onset and Death

1 yr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. causing Respiratory Failure
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36206

29d. Date signed (Month, Day, Year)

02/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keiran D. Mchta Leo Nantour MD 20639

31. Date filed (Month, Day, Year)

FEB 26 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH					
Charles Courn ENGLE				February 15, 1996				4:30 pm M					
4. SOCIAL SECURITY NUMBER 217-10-9289		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jul 20, 1907		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 742 Antietam Drive				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington					
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 742 Antietam Drive				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Pre- World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plasterer				16b. KIND OF BUSINESS/INDUSTRY Construction					
17. FATHER'S NAME (First, Middle, Last) Calvin Luther ENGLE				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ellen COUN									
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy F. Engle (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2001, Hagerstown, Maryland 21702-2001									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery Feb 19, 1996				DATE		20c. LOCATION — City or Town, State Frederick, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathryn Robinson</i> M00706				22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure / cardiac arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Heart failure</i> <i>Metastatic gallbladder cancer</i> d. <i>months</i> <i>weeks</i> <i>minutes</i>										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29c. LICENSE NUMBER 231880		29d. DATE SIGNED (Month, Day, Year) Feb 16, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Martin Gallagher, MD, 410 Medical Campus Road, Hagerstown, Maryland 21740													
31. DATE FILED (Month, Day, Year) FEB 21 1996		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>											

96 06866

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Spencer EDGAR				2. DATE OF DEATH MONTH DAY YEAR February 14, 1996		3. TIME OF DEATH 7:20 PM	
4. SOCIAL SECURITY NUMBER 223-70-6969		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 12, 1903		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Homewood Retirement Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 31 West Patrick Street				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Postal Employee		16b. KIND OF BUSINESS/INDUSTRY United States Post Office			
17. FATHER'S NAME (First, Middle, Last) Phillip Spencer EDGAR				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wortley Blanche RANSON			
19a. INFORMANT'S NAME (Type/Print) Anne Bird, Niece				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15708 Bondy Lane, Darnestown, MD 20878			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Lawn Cemetery, Feb. 16, 1996		20c. LOCATION — City or Town, State Richmond, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allan H Ruby MO0703				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death ~ 48 hrs.	
Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Urinary Tract infection</i> DUE TO (OR AS A CONSEQUENCE OF):				~ 48 hrs.	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Longstone Heart Failure</i> <i>Dementia</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 26499		29d. DATE SIGNED (Month, Day, Year) Feb. 15, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ronald E. Miller MD 4 Culwell Drive, Mt. Airy, Maryland 21771							
31. DATE FILED (Month, Day, Year) FEB 16 1996		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06867

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Randolph LeRoy Elliott				2. DATE OF DEATH MONTH DAY YEAR February 22, 1996		3. TIME OF DEATH #3:00 a^m	
4. SOCIAL SECURITY NUMBER 188-10-1513		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 1, 1912	
9a. FACILITY NAME (If not institution, give street and number) Chestertown Nursing and Rehabilitation Center				9b. CITY, TOWN OR LOCATION OF DEATH Chestertown		9c. COUNTY OF DEATH Kent	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Queen Annes		10c. CITY, TOWN OR LOCATION Chestertown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 301 Pine Tree Road				10f. ZIP CODE 21620		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7 Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Equipment Operator		16b. KIND OF BUSINESS/INDUSTRY Scrap Metal			
17. FATHER'S NAME (First, Middle, Last) Samuel George Elliott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Davis			
19a. INFORMANT'S NAME (Type/Print) Haywood D. Elliott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Pine Tree Road, Chestertown, Maryland 21620			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pleasant Cemetery/February 27, 1996		20c. LOCATION — City or Town, State Pondtown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary B. Fellows</i>				22. NAME AND ADDRESS OF FACILITY Fellows, Helffenstein, & Newman Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. END-STAGE RENAL DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John N. ...</i>				29c. LICENSE NUMBER D41587		29d. DATE SIGNED (Month, Day, Year) 2/26/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Helen Noble Speer Road Chestertown md 21620							
31. DATE FILED (Month, Day, Year) FEB 26 '96		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06868

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Russell Edward Flinn

2. Date of Death

February 17, 1996

3. Time of Death

11:49 a.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick Calvert

4c. County of Death

5. Social Security Number

233 44 6009

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16 1932

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12805 Bay Drive

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

office administration

16b. Kind of Business/Industry

service/utilities

17. Father's Name (First, Middle, Last)

Russell M. Flinn

18. Mother's Name (First, Middle, Maiden Surname)

Audra L. Tracowell

19a. Informant's Name/Relationship (Type, Print)

Jane L. Flinn- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12805 Bay Drive Lusby Maryland 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul Cemetery February 22, 1996

Date

20c. Location - City or Town, State

Lusby Maryland

21. Signature of Funeral Service Licensee

Rausch Funeral Home

22. Name and Address of Facility

Rausch Funeral Home

4405 Brookes Island Rd. Port Republic Maryland 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE ARRHYTHMIA

Approximate Interval Between Onset and Death

1 HOUR

Due to (or as a consequence of):

b. DILATED CARDIOMYOPATHY

1 YEAR

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

20 YRS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alfred Morgan

29c. License number

D23693

29d. Date signed (Month, Day, Year)

2/17/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFRED MORGAN CALVERT MEMORIAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature

J. J. Anderson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

96 06869

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clarence Yoder Fretz				2. DATE OF DEATH MONTH DAY YEAR 2/22/96		3. TIME OF DEATH 2015 M	
4. SOCIAL SECURITY NUMBER 230-50-0724		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 3, 1911	
8. BIRTHPLACE (State or Foreign Country) Penna.				9a. FACILITY NAME (If not institution, give street and number) Mennonite Fellowship Home		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE MD.			
10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Hagerstown			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 12349 Huyett Lane			
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) William D. Fretz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Yoder			
19a. INFORMANT'S NAME (Type/Print) Lela I. Fretz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12349 Huyett Lane Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mennonite Church Cemetery 2/26/96		20c. LOCATION — City or Town, State Cearfoss, Md.		20d. DATE 2/26/96	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE H. Martin Zimmerman Jr.				22. NAME AND ADDRESS OF FACILITY Zimmerman And Son Funeral Home Inc. Greencastle, Pa. 17225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia (aspiration) weeks Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Stroke Arteriosclerosis							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D26806		29d. DATE SIGNED (Month, Day, Year) 2/22/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Amanda B. MD 747 North Ave Hagerstown MD 21742							
31. DATE FILED (Month, Day, Year) FEB 26 1996		32. REGISTRAR'S SIGNATURE					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

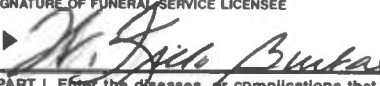
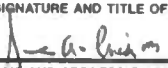
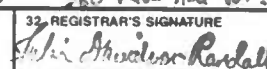
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

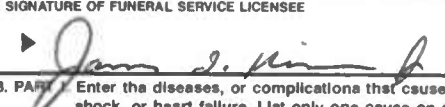

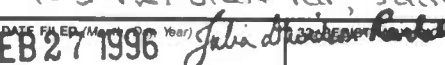
1. DECEDENT'S NAME (First, Middle, Last) David Duane Fox				2. DATE OF DEATH MONTH 2 DAY 19 YEAR 96				3. TIME OF DEATH 7:30 P			
4. SOCIAL SECURITY NUMBER 526-23-6936		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/17/59		8. BIRTHPLACE (State or Foreign Country) MI			
9a. FACILITY NAME (If not institution, give street and number) 303 Andover Dr.				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury				9c. COUNTY OF DEATH Wicomico			
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 303 Andover Dr.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1978-1987		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Respiratory Therapist		16b. KIND OF BUSINESS/INDUSTRY Health Care					
17. FATHER'S NAME (First, Middle, Last) Dennis D. Fox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Mabel Jones							
19a. INFORMANT'S NAME (Type/Print) Brian Fox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2237 N. Belvedere Tuscon, AZ 85712							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cape Henlopen Crematory 2/20/96 Frankford, DE		DATE 2/20/96		20c. LOCATION — City or Town, State Frankford, DE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 21811							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 month 11 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D45995		29d. DATE SIGNED (Month, Day, Year) 2/20/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jane A. Wick, MD 560 Riverside Dr. Suite A204 Salisbury, MD 21801											
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 							



96 06871

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RETTA W. FORD				2. DATE OF DEATH MONTH DAY YEAR Feb. 25, 1996		3. TIME OF DEATH 11:59 PM M	
4. SOCIAL SECURITY NUMBER 214-32-0881		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 31, 1917	
9a. FACILITY NAME (If not institution, give street and number) 29026 Revells Neck Road				9b. CITY, TOWN OR LOCATION OF DEATH Westover		9c. COUNTY OF DEATH Somerset	
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Westover		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 29026 Revells Neck Road				10f. ZIP CODE 21871		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife/Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY Own Home/Retail Sales			
17. FATHER'S NAME (First, Middle, Last) ROGER BARTON WHITE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ORRA READING			
19a. INFORMANT'S NAME (Type/Print) DONALD HALL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEAL ISLAND ROAD, PRINCESS ANNE, MD. 21853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Grace Episcopal Cemetery 2/29		20c. LOCATION — City or Town, State Mt. Vernon, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Cancer (Unknown Primary) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 6 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  M. S. Pruchan				29c. LICENSE NUMBER D26612		29d. DATE SIGNED (Month, Day, Year) 2.26.96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 103 Pitt Street Rd, Salisbury MD 21801.							
31. DATE FILED (Month, Day, Year) FEB 27 1996 32. SIGNATURE OF REGISTRAR 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911



1911 - 1912

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) MARY CHRISTIANA FLANIGAN				2. DATE OF DEATH MONTH DAY YEAR Feb. 24, 1996				3. TIME OF DEATH 6:55 A M	
4. SOCIAL SECURITY NUMBER 180-03-2374		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 26, 1911		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Walkersville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 400 Chapel Court				10f. ZIP CODE 21793		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk		16b. KIND OF BUSINESS/INDUSTRY Department Store			
17. FATHER'S NAME (First, Middle, Last) John M. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Avie C. Staley					
19a. INFORMANT'S NAME (Type/Print) Mary Frances Shafer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 Franklinville Road Thurmont, MD 21788					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Hope Cemetery		DATE 3/1/96		20c. LOCATION — City or Town, State Woodsboro, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death HOURS 18 DAYS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D43091	
29d. DATE SIGNED (Month, Day, Year) 2-26-96									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Saeed A. Zaidi 801 Toll House Avenue Frederick, MD 21701									
31. DATE FILED (Month, Day, Year) MAR 01 1996				32. REGISTRAR'S SIGNATURE 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06873

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley Lee Fink Sr.

2. Date of Death

Month Day Year
February 20, 1996

3. Time of Death

7:27 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-28-5620

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 14, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

421 North Bentz Street

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1953-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mechanic Heavy Equipment

16b. Kind of Business/Industry

Stone Products

17. Father's Name (First, Middle, Last)

Leonard

FINK

18. Mother's Name (First, Middle, Maiden Surname)

Minnie

GEOTZ

19a. Informant's Name/Relationship (Type, Print)

Mrs. Martha Jane Fink, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 North Bentz Street, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gardens, Feb. 24, 1996 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard E. Draf M00255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Hypotension

Due to (or as a consequence of):

b.

HEPATIC FAILURE

Due to (or as a consequence of):

c.

ETOH Abuse

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

24hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 8 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mark A. Rubin MD

29c. License number

D29522

29d. Date signed (Month, Day, Year)

2/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK A RUBIN 56 THOMAS JOHNSON DR FREDERICK

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

John A. Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 06874

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Daniel Fleming				2. DATE OF DEATH MONTH DAY YEAR 03-03-96		3. TIME OF DEATH 3:00 PM	
4. SOCIAL SECURITY NUMBER 579-40-1812		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-04-30	
8. FACILITY NAME (If not institution, give street and number) 7105 Sheffield Drive				9. CITY, TOWN OR LOCATION OF DEATH Temple Hills		10. COUNTY OF DEATH Prince Georges	
11. STATE MD				12. COUNTY Prince Georges		13. CITY, TOWN OR LOCATION Temple Hills	
14. STREET AND NUMBER 7105 Sheffield Drive				15. ZIP CODE 20748		16. CITIZEN OF WHAT COUNTRY? USA	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: Black	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Counselor		23. KIND OF BUSINESS/INDUSTRY Drug Education			
24. FATHER'S NAME (First, Middle, Last) Duvall Fleming				25. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Jackson Fleming			
26. INFORMANT'S NAME (Type/Print) Bertha Fleming				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 Sheffield Drive Temple Hills, MD 20748			
28. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CountyLine Bapt. Cem 3/09		30. DATE 3/09		31. LOCATION — City or Town, State Goochland, VA	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE John E. Thomasson				33. NAME AND ADDRESS OF FACILITY Thomasson's Funeral Service, Inc. P. O. Box 512 117 West St. Louisa, VA 23093			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
36. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		37. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
38. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		39. DATE OF INJURY (Month, Day, Year)		40. TIME OF INJURY M		41. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
42. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		43. DESCRIBE HOW INJURY OCCURRED					
44. LOCATION (Street and Number or Rural Route Number, City or Town, State)		45. DATE SIGNED (Month, Day, Year) 3-03-96					
46. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
47. SIGNATURE AND TITLE OF CERTIFIER John E. Thomasson, MD				48. LICENSE NUMBER 12208		49. DATE SIGNED (Month, Day, Year) 3-03-96	
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAZEL TAPE, MD 1011 NORTH CAPITOL, WASHINGTON, D.C. 20002							
51. DATE FILED (Month, Day, Year) MAR 11 1996				52. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06875

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARCUS GOTSIS				2. Date of Death Month Day Year February 24 1996		3. Time of Death 0145	
	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death PRINCE FREDERICK		4c. County of Death CALVERT	
Funeral Director	5. Social Security Number 578-09-8906		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Sep. 7, 1918	
	9. Birthplace (State or Foreign Country) Wisconsin		10a. State Maryland		10b. County Calvert		10c. City, Town or Location 6405 2nd Street N., Chesapeake Beach	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6405 2nd Street North		10f. Zip Code 20732		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> Collega (1-4 or 5+) <input type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) roofer		16b. Kind of Business/Industry construction				
17. Father's Name (First, Middle, Last) Louis Gotsopoulos				18. Mother's Name (First, Middle, Maiden Surname) Angeline Lampiris				
19a. Informant's Name/Relationship (Type, Print) Ella C. Ramp / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6342 Bayside Road, Chesapeake Beach, MD				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 2/28/96 Alexandria, VA		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. chronic arteriosclerotic Due to (or as a consequence of): b. cardiovascular disease Due to (or as a consequence of): c. diabetes with cardiac Due to (or as a consequence of): d. artery due to above Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 						
		29c. License number D03077		29d. Date signed (Month, Day, Year) 2/24/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISSAM DAMALOUJI, M.D. PRINCE FREDERICK, MD. 20678								
31. Date filed (Month, Day, Year) FEB 27 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06876

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine

Agnes

Green

2. Date of Death

February 15 1996

Day Year

3. Time of Death

1811

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-07-3862

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 23, 1904

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13457 Old Annapolis Road

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home.

17. Father's Name (First, Middle, Last)

Cornelius P. Judge

18. Mother's Name (First, Middle, Maiden Surname)

Catherine A. (unknown)

19a. Informant's Name/Relationship (Type, Print)

Robert O. Green - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12132 Suffolk Terrace, Gaithersburg, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

2/19

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

John L. Williams

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland

20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

MINUTES

Due to (or as a consequence of):

b. METASTATIC CANCER OF UNKNOWN PRIMARY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kanan Hudson, MD

29c. License number

D41866

29d. Date signed (Month, Day, Year)

FEBRUARY 16, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANAN HUDSON, MD

481 N. FREDERICK AVE, 230

GAITHERSBURG, MD 20877

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

Julia Davidson Roberts

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

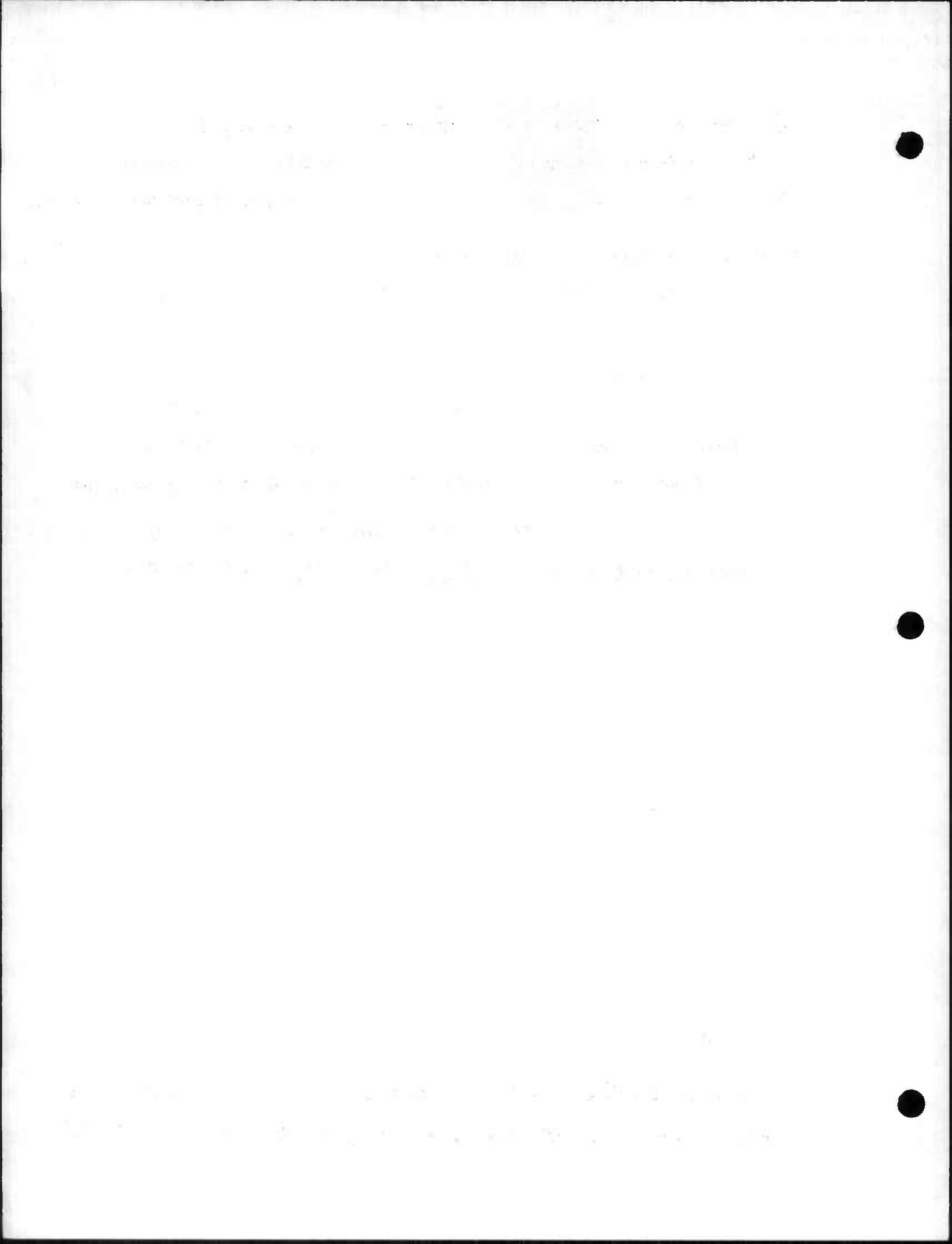
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06877

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Logan GRIFFITH				2. DATE OF DEATH MONTH February DAY 21 , YEAR 1996		3. TIME OF DEATH 1:30 P M		
4. SOCIAL SECURITY NUMBER 212-20-7060		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 11, 1926		8. BIRTHPLACE (State or Foreign Country) Delaware	
9a. FACILITY NAME (If not institution, give street and number) 220 East Third Street				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT								
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 220 East Third Street				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Communications Person		16b. KIND OF BUSINESS/INDUSTRY City Police Department		
17. FATHER'S NAME (First, Middle, Last) Logan GRIFFITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth GAY				
19a. INFORMANT'S NAME (Type/Print) Mrs. Marie Elizabeth Sweadner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 68 Libertytown, Maryland 21762				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Hope Cemetery, February 23, 1996		20c. LOCATION — City or Town, State Woodsboro, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Hraf M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE M.I.								
DUE TO (OR AS A CONSEQUENCE OF): ASCVD								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { Insulin dependent Diabetes mellitus								
DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - HYPERTENSION								
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD				29c. LICENSE NUMBER D 31912		29d. DATE SIGNED (Month, Day, Year) 2/22/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JULIO MEMOCAL, MD - 1564 OPOSSUMTOWN PIKE, FREDERICK, MD 21702.								
31. DATE FILED (Month, Day, Year) FEB 23 1996				32. REGISTRAR'S SIGNATURE [Signature]				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06878

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Melvin HARBAUGH

2. Date of Death
Month Day Year

February 23 1996

3. Time of Death
0115 am

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

214-09-3475A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Dec. 31, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

50 West Side Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0-5

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

retailer

building materials

17. Father's Name (First, Middle, Last)

Clarence Fleet Harbaugh

18. Mother's Name (First, Middle, Maiden Surname)

Maude Trovinger

19a. Informant's Name/Relationship (Type, Print)

Mr. Kenneth E. Harbaugh

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17323 Diane Drive, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

2-26-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Fred L. L. L.

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cancer of esophagus with metastases

c. Lymph node metastases

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

gastroenteritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D18727

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O. E. Su. MD 370 Mill Street, Hagerstown MD 21740

31. Date filed (Month, Day, Year)

FEB 27 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

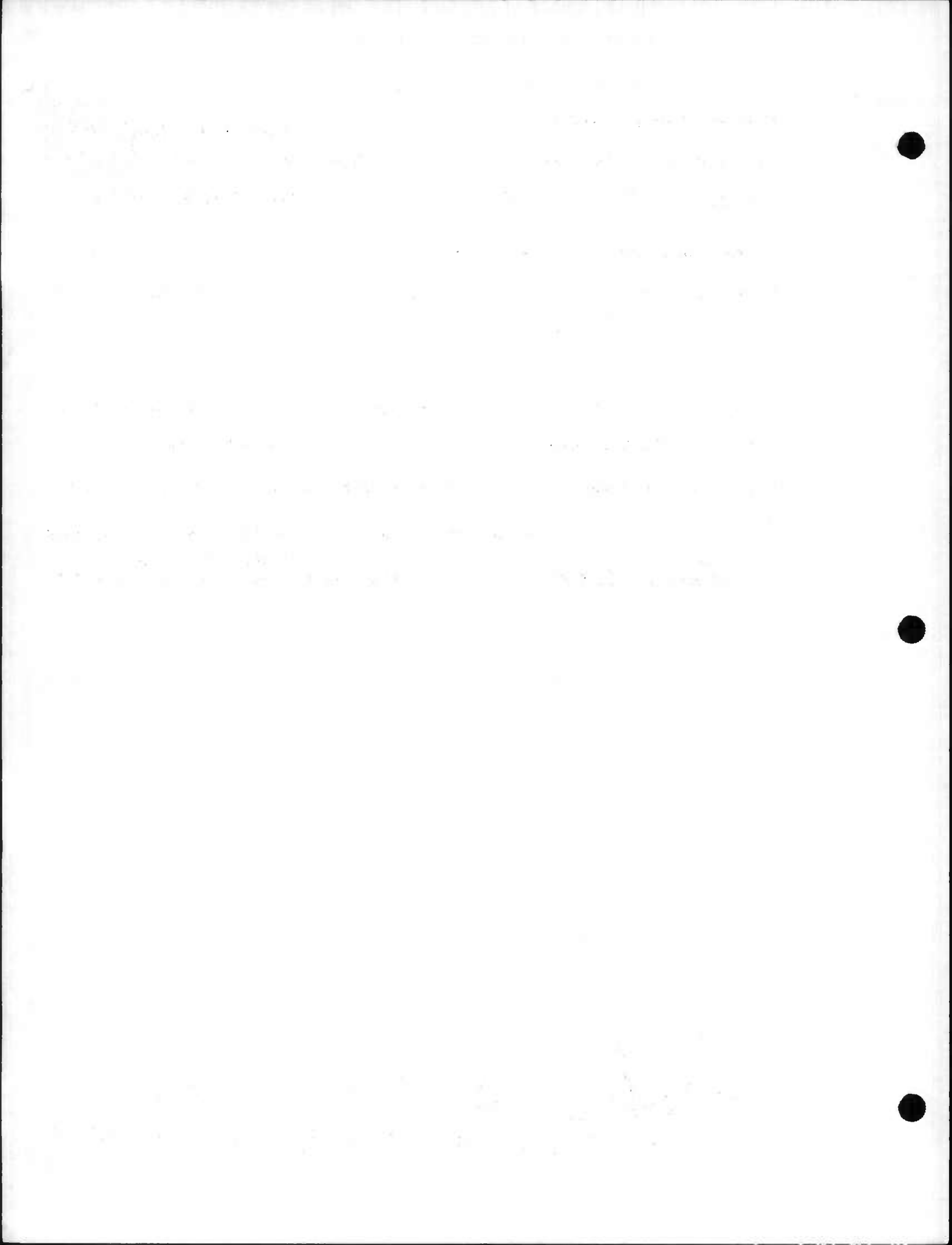
Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06879

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK HARRISON				2. DATE OF DEATH MONTH 2 DAY 30 YEAR 96		3. TIME OF DEATH 6:30 A.M.			
4. SOCIAL SECURITY NUMBER 214-36-5206		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/27/07		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Snow Hill Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Snow Hill, Md.			9c. COUNTY OF DEATH Worcester		
10a. STATE Md.		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Snow Hill			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER S. Church Street #418				10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) farmer		16b. KIND OF BUSINESS/INDUSTRY farm laborer					
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Conway					
19a. INFORMANT'S NAME (Type/Print) Lottie Melson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 14, Greenbush, Virginia 23357					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Spence Baptist Cemet. 2/22		20c. LOCATION — City or Town, State Snow Hill, Md. 21863					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia L. Dennis</i>				22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home P.O. Box 87, Snow Hill, Md. 21863					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): CARDIO - MANY YRS Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LYMPHOMA						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dorothy C. Holzworth M.D.</i>				29c. LICENSE NUMBER D06241		29d. DATE SIGNED (Month, Day, Year) 2-20-96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DOROTHY C. HOLZWORTH 203 SNOW ST. SNOW HILL, MD. 21863									
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson-Russell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06880

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jessie Theodore Harris, Sr.

2. Date of Death

Month Day Year
February 16, 1996

3. Time of Death

9:20 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-16-2071

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 27, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Ijamsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9719 Fingerboard Rd.

10f. Zip Code

21754

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farm work

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

William Bowie

18. Mother's Name (First, Middle, Maiden Surname)

Gussie G.

19a. Informant's Name/Relationship (Type, Print)

Sterling T. Harris (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1741 Northridge Lane/ Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ebenezer Cemetery

Date

2-21-96

20c. Location - City or Town, State

Ijamsville, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike/ Frederick, Md. 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PRERENAL AZOTEMIA

e. Due to (or as a consequence of):

DEHYDRATION

b. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

5 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

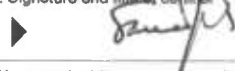
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D43091

29d. Date signed (Month, Day, Year)

February 22, 1996

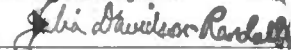
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAEED A. ZAIDI, 801 Toll House Ave. / Frederick Maryland 21701

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

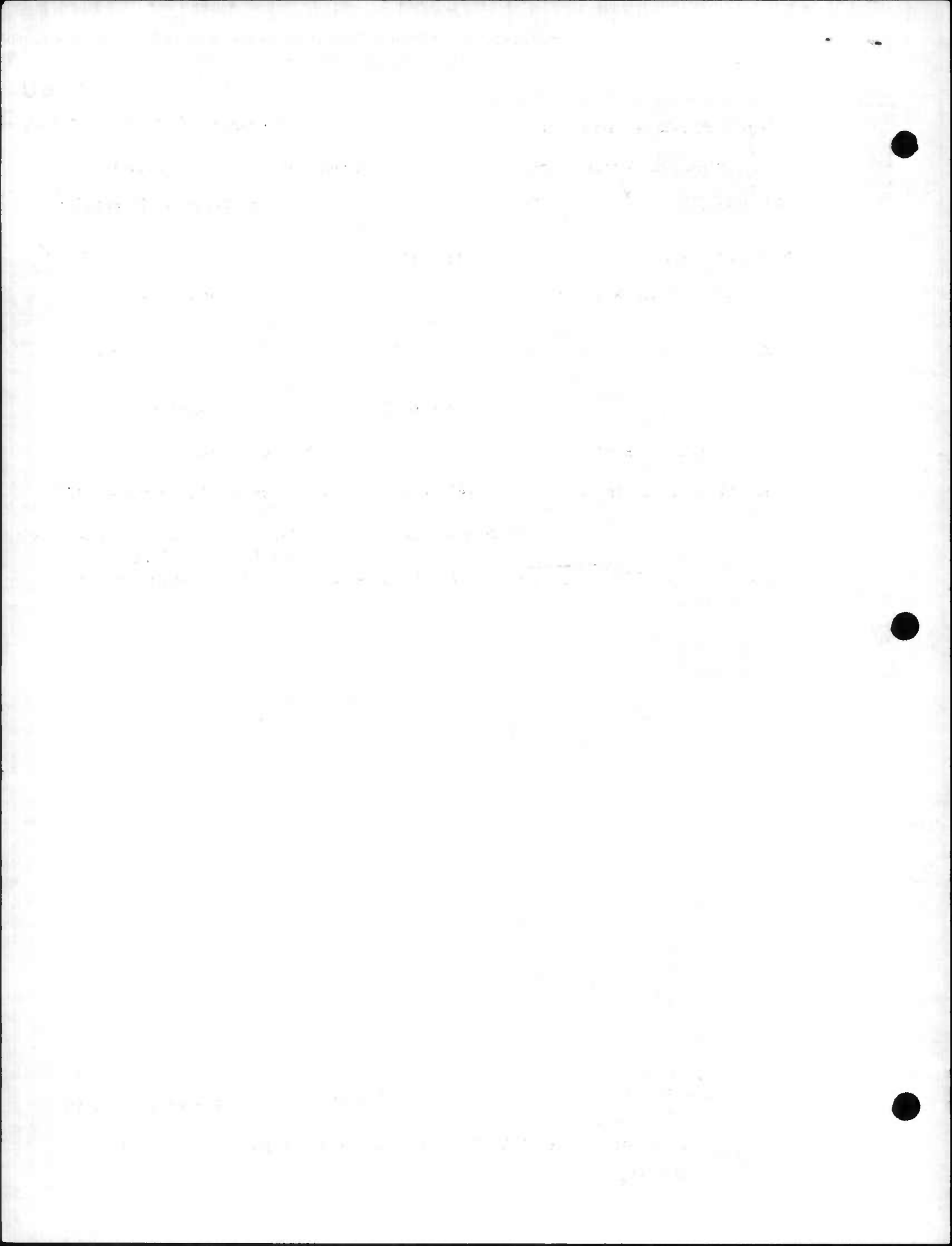
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06881

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILSON HARLAN HORNBERGER				2. DATE OF DEATH MONTH DAY YEAR February 13, 1996		3. TIME OF DEATH 9:48 A.M.	
4. SOCIAL SECURITY NUMBER 212-03-1272		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 25, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6309 Mountaindale Road		10f. ZIP CODE 21788	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automotive Electrician		16b. KIND OF BUSINESS/INDUSTRY Battery Company	
17. FATHER'S NAME (First, Middle, Last) William Edwin Hornberger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Magdalena Frash			
19a. INFORMANT'S NAME (Type/Print) Catherine G. Hornberger, wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6309 Mountaindale Road Thurmont, Maryland 21788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 2/15/96 Frederick, Maryland			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ARTERY DISEASE DUPLICATE TO (OR AS A CONSEQUENCE OF): b. DUPLICATE TO (OR AS A CONSEQUENCE OF): c. DUPLICATE TO (OR AS A CONSEQUENCE OF): d. DUPLICATE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER David M. Summers DO			
29c. LICENSE NUMBER H39804				29d. DATE SIGNED (Month, Day, Year) 2-14-96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID M. SUMMERS, 915 TOLL HOUSE AVE., FREDERICK, MD							
31. DATE FILED (Month, Day, Year) FEB 16 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06882

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

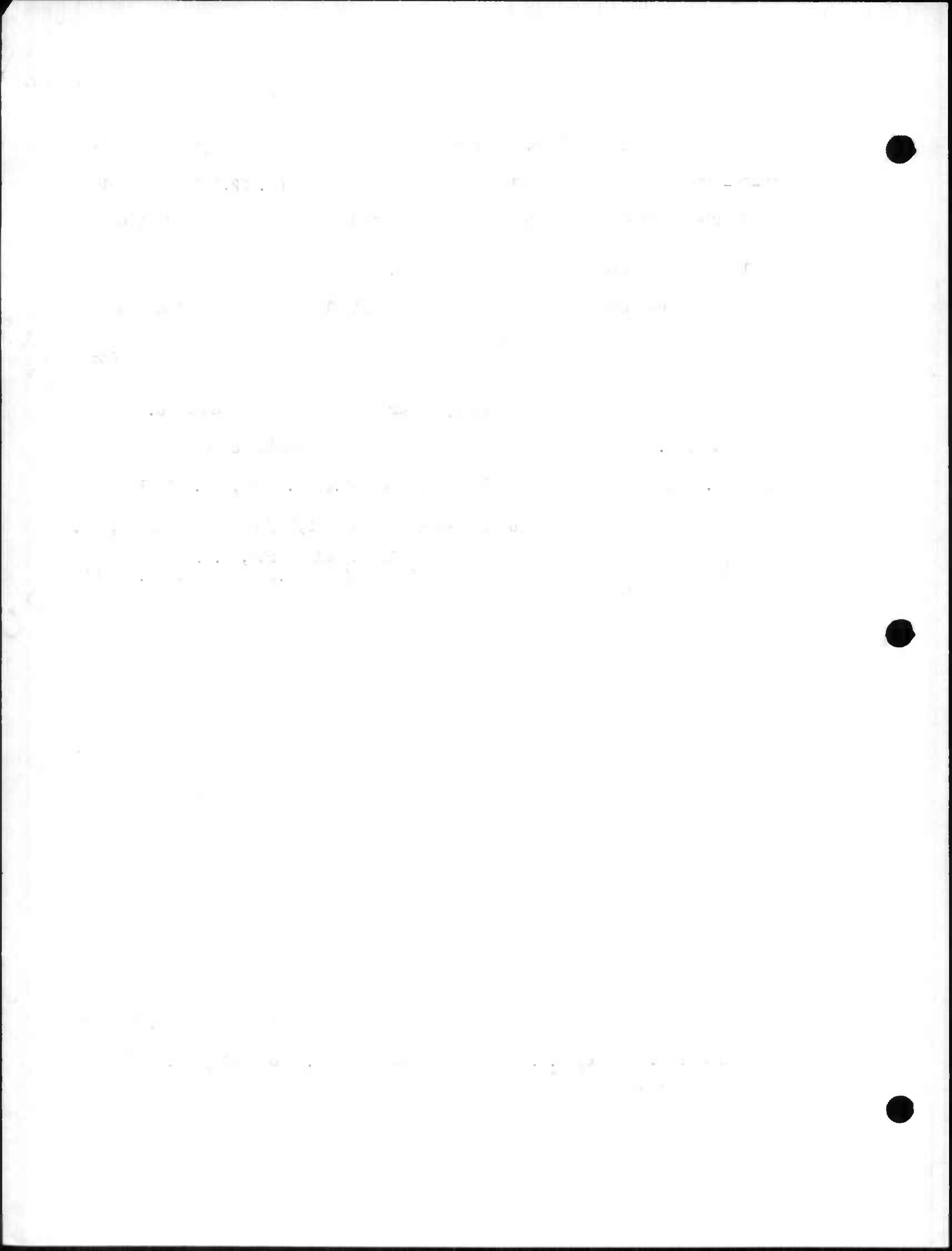
1. DECEDENT'S NAME (First, Middle, Last) James Albert Hardy				2. DATE OF DEATH MONTH DAY YEAR February 6, 1996		3. TIME OF DEATH 1:45 P M	
4. SOCIAL SECURITY NUMBER 217-36-4176		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 22, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
9b. FACILITY NAME (If not institution, give street and number) Frederick Health Care Center							
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Mt. Airy		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1670 Florence Road				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Manager		16b. KIND OF BUSINESS/INDUSTRY Tractor Co.			
17. FATHER'S NAME (First, Middle, Last) Arthur R. Hardy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cylettie Lowman			
19a. INFORMANT'S NAME (Type/Print) Irene P. Hardy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1670 Florence Rd., Mt. Airy, Md. 21771			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Howard Chapel Cemetery 2/10/96		20c. LOCATION — City or Town, State Long Corner, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Olin L. Molesworth				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain Tumor & complications Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Arthur G. Manalo, M.D.				29c. LICENSE NUMBER D-18191		29d. DATE SIGNED (Month, Day, Year) Feb. 7, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur G. Manalo, M.D. 11801 Fingerboard Rd., Monrovia, Md. 21770							
31. DATE FILED (Month, Day, Year) FEB 12 1996				32. REGISTRAR'S SIGNATURE			

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 96 06883

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD L HESSEY

2. Date of Death

Month
FEB

Day
21

Year
1996

3. Time of Death

1745

4a. Facility Name (If not institution, give street and number)

UNIV OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

212-24-8892

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 27, 1928

9. Birthplace (State or Foreign Country)

Georgetown, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Georgetown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Box 1

10f. Zip Code

21930

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Commercial Waterman

16b. Kind of Business/Industry

Seafood Industry

17. Father's Name (First, Middle, Last)

Howard Thomas Hessey

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Hiliditch

19a. Informant's Name/Relationship (Type, Print)

Ida Mae Hessey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 1, Georgetown, Maryland 21930

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Galena Cemetery/February 25, 1996

Date

20c. Location - City or Town, State

Galena, Maryland

21. Signature of Funeral Service Licensee

Gary B. Fellows

22. Name and Address of Facility

Fellows, Helfenbein, & Newman Funeral Home, P.A.
370 W. Cypress Street, Millington, Maryland 21651

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypoxic Encephalopathy

Approximate Interval Between Onset and Death

2 weeks

Due to (or as a consequence of):

Coronary Artery Bypass Grafting

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D46015

29d. Date signed (Month, Day, Year)

FEB 21 1996

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DOUGLAS WALLACE, DEPT OF HEALTH, UNIV OF MARYLAND
22 S. GREEN ST. BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

FEB 26 '96

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

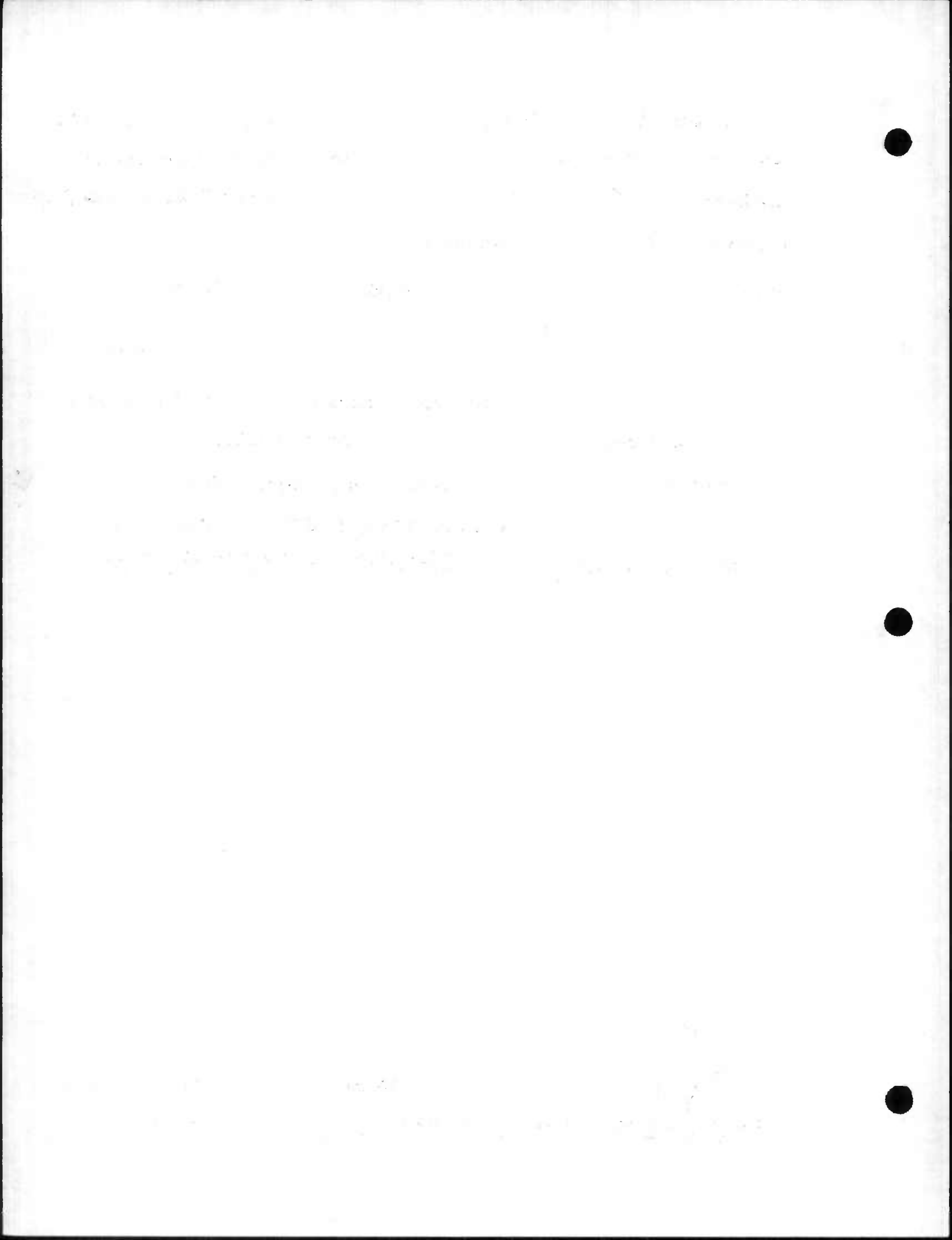
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06884

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Georges Said Jaar				2. DATE OF DEATH MONTH DAY YEAR February 17, 1996				3. TIME OF DEATH 7:30 PM	
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 4, 1928		8. BIRTHPLACE (State or Foreign Country) Dominican Republic	
9a. FACILITY NAME (If not institution, give street and number) 4910 Camden Place, North				9b. CITY, TOWN OR LOCATION OF DEATH Jefferson				9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Jefferson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4910 Camden Place, North				10f. ZIP CODE 21775		10g. CITIZEN OF WHAT COUNTRY? Haiti			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self		16b. KIND OF BUSINESS/INDUSTRY Automobile Retail Sales			
17. FATHER'S NAME (First, Middle, Last) Said Georges Jaar				18. MOTHER'S NAME (First, Middle, Maiden Surname) Menneh Talamas					
19a. INFORMANT'S NAME (Type/Print) Carol Sepe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4465 Lewis Mill Ct., Jefferson, MD 21775					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 2/20/96		20c. LOCATION — City or Town, State Frederick, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kuan H. Bess</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cancer of Esophagus</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 12 mos									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Emphysema</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arlene A. Forastiere MD</i>				29c. LICENSE NUMBER D 25773		29d. DATE SIGNED (Month, Day, Year) 2/19/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARLENE A. FORASTIERE MD 600 N. WOLFE ST. BALT. MD.									
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>J. A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06885

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charlotte Jean Johnson				2. DATE OF DEATH MONTH DAY YEAR February 13 1996		3. TIME OF DEATH 1:30 P.M.	
4. SOCIAL SECURITY NUMBER 214-28-5118		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 16, 1931	
8. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Walkersville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8802 Biggs Ford Road				10f. ZIP CODE 21793		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) machine operator		16b. KIND OF BUSINESS/INDUSTRY refridgeration/air cond.			
17. FATHER'S NAME (First, Middle, Last) Norvell Thomas Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Laura Hoke Clabaugh			
19a. INFORMANT'S NAME (Type/Print) Anthony Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Liberty Street, Walkersville, MD 21793			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 1996		20c. LOCATION — City or Town, State Hagerstown, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ayan M. Berger				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pk. Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael Lerner MD				29c. LICENSE NUMBER D41619		29d. DATE SIGNED (Month, Day, Year) February 17, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Lerner MD, 15 E. Frederick Street, Walkersville, MD 21793							
31. DATE FILED (Month, Day, Year) FEB 16 1996				32. REGISTRAR'S SIGNATURE Julia Davidson Randolph			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended line / JLD, FCHD as Per Funeral Director 98 06886

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES, RONALD EUGENE				2. DATE OF DEATH MONTH DAY YEAR February 10, 1996				3. TIME OF DEATH 11:18 AM			
4. SOCIAL SECURITY NUMBER 215-78-4640		5. SEX XX M 2 F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 10, 1960		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
10e. STREET AND NUMBER 407 West Diamond Avenue				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stocker		16b. KIND OF BUSINESS/INDUSTRY Department Store					
17. FATHER'S NAME (First, Middle, Last) William H. James				18. MOTHER'S NAME (First, Middle, Maiden Surname) Geraldine D. Hoy							
19a. INFORMANT'S NAME (Type/Print) William H. James, father				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 South Federal Street New Market, MD 21774							
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 2/14/96 Frederick, Maryland		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry R. Sangs</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ACQUIRED IMMUNO-DEFICIENCY SYNDROME b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death 5 5			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UPPER GASTROINTESTINAL BLEED RENAL FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN								24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29c. SIGNATURE AND TITLE OF CERTIFIER <i>Charles A. Obiotta</i> MD / OB10HA				29d. LICENSE NUMBER 47723		29e. DATE SIGNED (Month, Day, Year) FEBRUARY 10 1996					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES A. OBIOTTA, M.D.											
31. DATE FILED (Month, Day, Year) FEB 12 1996				32. REGISTRAR'S SIGNATURE <i>John A. Randolph</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06887

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Cecil Johnson				2. DATE OF DEATH MONTH February DAY 9 YEAR 1996		3. TIME OF DEATH 9:24 P.M.	
4. SOCIAL SECURITY NUMBER 232-58-9813		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 7, 1937	
8. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9a. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Damascus		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 26615 Haney Avenue				10f. ZIP CODE 20872		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1956-1960		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Equipment		16b. KIND OF BUSINESS/INDUSTRY Private Industry			
17. FATHER'S NAME (First, Middle, Last) Joseph E. Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Irene Moses			
19a. INFORMANT'S NAME (Type/Print) Nancy Ann Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26615 Haney Avenue, Damascus, Maryland 20872			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pine Grove Cemetery		DATE 2/13		20c. LOCATION — City or Town, State Mount Airy, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert L. Williams				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. congestive heart failure c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thai McGreiv, MD				29c. LICENSE NUMBER D47093		29d. DATE SIGNED (Month, Day, Year) February 9, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thai McGreiv, M.D. 9901 Medical Center Drive Rockville, Maryland 20855							
31. DATE FILED (Month, Day, Year) FEB 12 1996				32. REGISTRAR'S SIGNATURE Barbara Randolph			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06888

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>WILLIAM POTTER KINGSLEY</i>				2. DATE OF DEATH MONTH <i>FEB</i> DAY <i>26</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>9:30P M</i>	
4. SOCIAL SECURITY NUMBER <i>090-09-5851</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 15 1907</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>COFFMAN NURSING HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1040 Matthew Court</i>			
10f. ZIP CODE <i>21742</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Owner/operator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Retail Sales</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Henry Eliza Kingsley</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Catherine Butler</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Virginia Kingsley</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1040 Matthew Court Hagerstown, Md. 21742</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hagerstown Crematory 2-29-96</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY <i>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>End Stage Cardiomyopathy</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>renal failure</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>11</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i> <i>Chronic lung disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Samuel Chan MD</i>				29c. LICENSE NUMBER <i>D36055</i>		29d. DATE SIGNED (Month, Day, Year) <i>2/27/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SAMUEL CHAN, M.D. 1185 Mt. Actna Rd. HAGERSTOWN MD 21740</i>							
31. DATE FILED (Month, Day, Year) <i>MAR - 1 1996</i>				32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

80000 34

RECEIVED

1904

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06889

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John M. King

2. Date of Death

Month
02Day
14Year
96

3. Time of Death

12:46 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

216-40-9489

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 2, 1942

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26301 Long Corner Road

10f. Zip Code

20882

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4or 5+)
8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Trial Law

17. Father's Name (First, Middle, Last)

Clark F. King

18. Mother's Name (First, Middle, Maiden Surname)

Grace Souder

19a. Informant's Name/Relationship (Type, Print)

Alice Meyers King - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26301 Long Corner Road, Gaithersburg, Maryland 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Damascus Methodist Cemetery 2/17 Damascus, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James L. Williams

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland

20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR Fibrillation

Due to (or as a consequence of):

10 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute MYOCARDIAL Infarction

Due to (or as a consequence of):

10 hours

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid Obesity

Chronic atrial Fibrillation

Glucose Intolerance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory H. Fisher

29c. License number

D26443

29d. Date signed (Month, Day, Year)

February 14, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory H. Fisher 15225 Shady Grove Road Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

FEB 21 1996

32. Registrar's Signature

Julia Devlin Rastall

State
Registrar

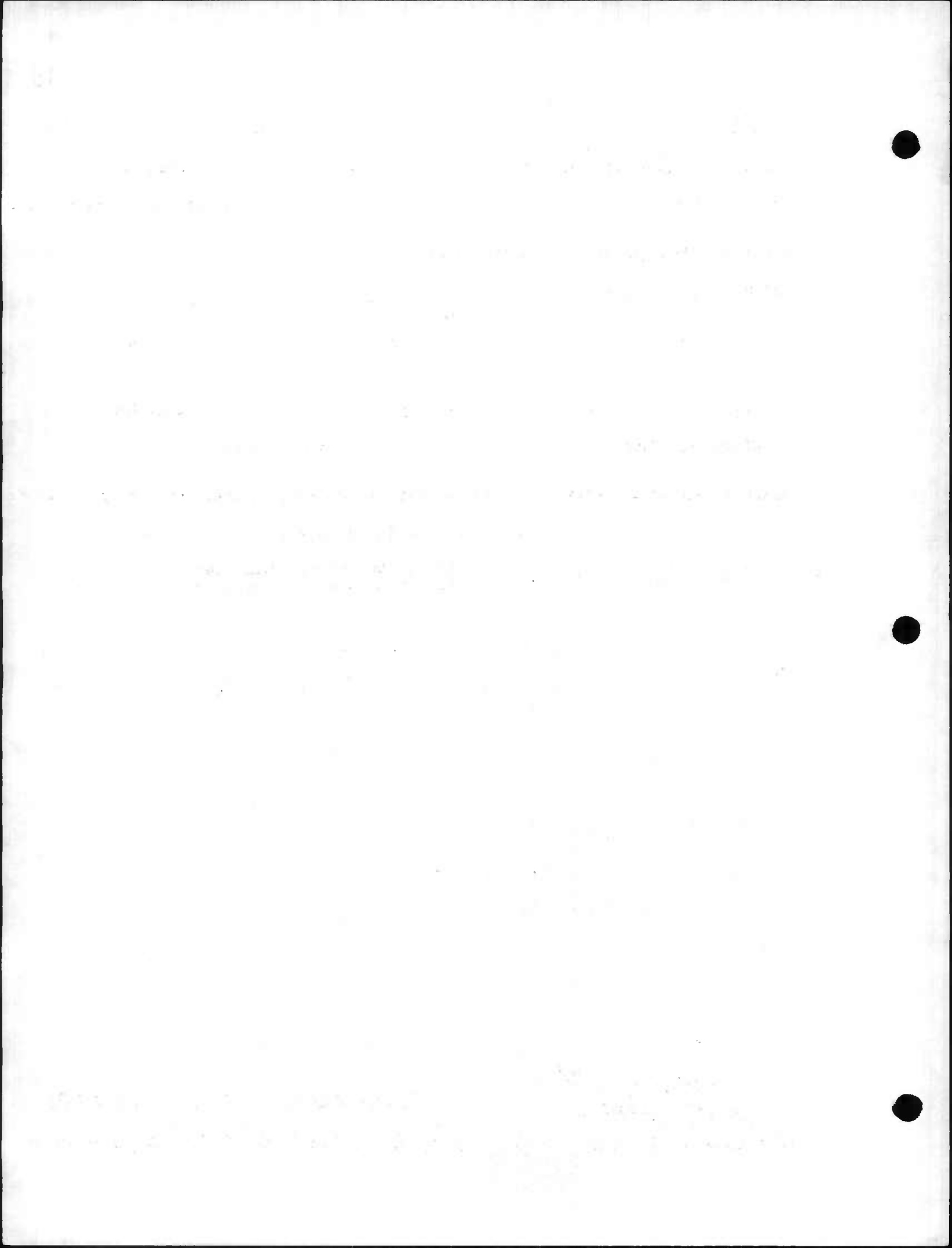
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06890

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY BERNADETTE KILLIAN, SND				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1996		3. TIME OF DEATH 10:30P. M	
4. SOCIAL SECURITY NUMBER 207-40-0576		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 5, 1909	
8. BIRTHPLACE (State or Foreign Country) LYNN, MA.				9a. FACILITY NAME (If not institution, give street and number) ST. CATHERINE'S NURSING CENTER		9b. CITY, TOWN OR LOCATION OF DEATH EMMITSBURG	
9c. COUNTY OF DEATH FREDERICK				10a. STATE MARYLAND		10b. COUNTY FREDERICK	
10c. CITY, TOWN OR LOCATION EMMITSBURG				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 331 S. SETON AVE.,	
10f. ZIP CODE 21727				10g. CITIZEN OF WHAT COUNTRY? U. S. A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY SISTER OF NOTRE DAME	
17. FATHER'S NAME (First, Middle, Last) JOHN MICHAEL KILLIAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE SHERIN			
19a. INFORMANT'S NAME (Type/Print) MARY ADELE WHITE, SND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 WINDWARD CT., THURMONT, MD. 21788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SISTERS OF NOTRE DAME 2/19/96		20c. LOCATION — City or Town, State ELLCOTT CITY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Skiles</i>				22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>starvation</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>inability to swallow</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Alzheimer's dz, end stage</i>						Approximate Interval Between Onset and Death immediate 2 wks yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christine Curley, M.D.</i> physician		29c. LICENSE NUMBER D39937		29d. DATE SIGNED (Month, Day, Year) FEB. 14, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTINE CURLEY, M.D., 302 W. MAIN ST., EMMITSBURG, MD. 21727							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>John A. Davidson-Rodolph</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06891

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Oliver Hendrix KEEFER				2. DATE OF DEATH MONTH February DAY 12 , 1996 YEAR				3. TIME OF DEATH 2:45 PM	
4. SOCIAL SECURITY NUMBER 214-10-4300		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH (Month, Day, Year) November 6, 1906	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Northampton Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland				10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 528 Wilson Place	
10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) Foreman/Supervisor				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman/Supervisor				16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Frank KEEFER				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie SMITH				19a. INFORMANT'S NAME (Type/Print) Mrs. Sandra Kay Gustafson	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Darwyn Drive, Windsor, Connecticut 06905				20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Mount Olivet Cemetery, Feb. 16, 1996	
20c. LOCATION — City or Town, State Frederick, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Draf M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary heart failure DUE TO (OR AS A CONSEQUENCE OF): Myocardium Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate interval Between Onset and Death 1-2y.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Robert S. Hughes MD				29c. LICENSE NUMBER D 05111				29d. DATE SIGNED (Month, Day, Year) Feb. 13, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert S. Hughes MD 700 Montclair Avenue, Frederick, Maryland 21701				31. DATE FILED (Month, Day, Year) FEB 14 1996				32. REGISTRAR'S SIGNATURE John Davidson Raskall	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06892

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM JOHN THOMER LONG IV				2. Date of Death Month Day Year FEBRUARY 26, 1996		3. Time of Death 2:30AM		
	4a. Facility Name (If not institution, give street and number) MD. ROUTES #40 & #66				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON		
Funeral Director	5. Social Security Number 260-53-6050		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 17 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 13 1978		
	9. Birthplace (State or Foreign Country) Georgia		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 420 Fremont Street		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Not employed		16b. Kind of Business/Industry -----					
17. Father's Name (First, Middle, Last) William John Thomer Long, III				18. Mother's Name (First, Middle, Maiden Surname) Linda Conklin					
19a. Informant's Name/Relationship (Type, Print) William J.T. Long, III				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Fremont Street Hagerstown, Maryland 21740					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park 3-1-96 Hagerstown, Maryland		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee <i>Scott M. Minnick</i>				22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. GUNSHOT WOUND OF HEAD, CONTACT Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2/26/96		28b. Time of Injury 0200 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT SHOT SELF	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STORE		28f. Location (Street and Number or Rural Route Number, City or Town, State) MD ROUTES # 40 & 66, HAGERSTOWN					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 26, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLUE JR MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) FEB 28 1996		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06893

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Woodrow Lewis

2. Date of Death
Month Day Year

February 24, 1996

3. Time of Death

5:54 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

213-09-9721

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 5, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Myersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11943 Wolfsville Road

10f. Zip Code

21773

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Excavating

17. Father's Name (First, Middle, Last)

Levin Theodore Lewis

18. Mother's Name (First, Middle, Maiden Summa)

Trixie Victoria Delauter

19a. Informant's Name/Relationship (Type, Print)

Gene Lewis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12021 Wolfsville Road, Myersville, Maryland 21773

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Mark's Lutheran Cemt 2/17/96 Wolfsville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

P.O. Box 136
Ricketts Funeral Home Myersville, MD 21773

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Concussion Injury*

Due to (or as a consequence of):

b. *Concussive Head Injury*

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d. Approximate
Interval Between
Onset and Death

4-5

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30721

29d. Date signed (Month, Day, Year)

2/25/96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

P. L. Ricketts, 110 W. 5th St, Frederick, MD 21704

31. Date of Death (Month, Day, Year)

FEB 26 1996

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

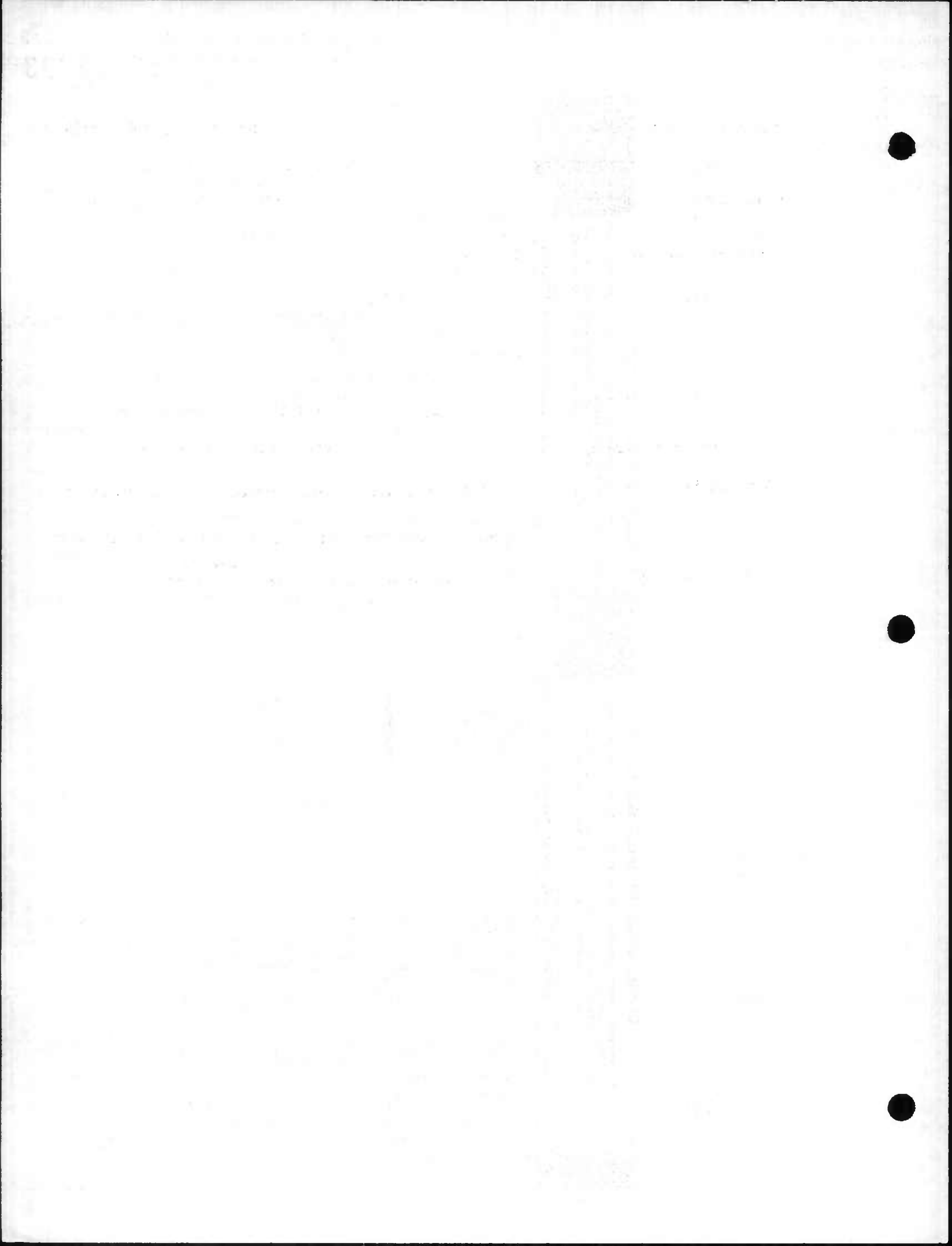
Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

State
Registrar



96 06894

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>PAUL H Jacqueline Leroux</i>				2. DATE OF DEATH MONTH <i>February</i> DAY <i>13</i> YEAR <i>1996</i>		3. TIME OF DEATH <i>1:33 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>417-70-7810</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>71</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 9 1924</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Canada</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>	
9c. COUNTY OF DEATH <i>Montgomery</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Montgomery</i>	
10c. CITY, TOWN OR LOCATION <i>Gaithersburg</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>407 West Diamond Avenue</i>	
10f. ZIP CODE <i>20884</i>				10g. CITIZEN OF WHAT COUNTRY? <i>Canada</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>secretary</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <i>secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>National Geographic</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Maurice Lavigne</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alphonsine LeFebure</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Andre LeRoux</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8830 Challenge Walk Walkersville, MD 21793</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Mary's</i>		20c. LOCATION — City or Town, State <i>2/19 Barnesville, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William C. Hill</i>				22. NAME AND ADDRESS OF FACILITY <i>Hilton Funeral Home 22111 Beallsville Rd Barnesville MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>metastatic breast cancer</i> b. c. d. Approximate Interval Between Onset and Death <i>3 days</i> <i>5 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cord compression secondary to cancer</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George A. Santos MD</i>				29c. LICENSE NUMBER <i>D43083</i>		29d. DATE SIGNED (Month, Day, Year) <i>February 13, 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. George A. Santos 9707 Medical Center Drive Rockville</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 21 1996</i>				32. REGISTRAR'S SIGNATURE <i>John A. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

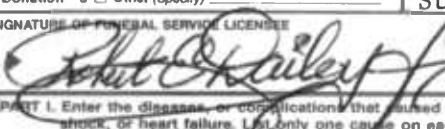
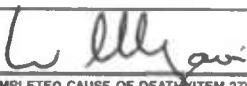

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06895

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) MARY VALENIA LAMBERT				2. DATE OF DEATH MONTH DAY YEAR Feb. 12, 1996		3. TIME OF DEATH 4:00 AM	
4. SOCIAL SECURITY NUMBER 212-14-7830		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 27, 1907	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 3701 Tuck Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Point of Rocks	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Point of Rocks				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3701 Tuck Avenue	
10f. ZIP CODE 21777				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY None	
17. FATHER'S NAME (First, Middle, Last) Edward Hefner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Mae Oden			
19a. INFORMANT'S NAME (Type/Print) Brian Wynkoop				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 North Pendleton Court, Frederick, Maryland 21703			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Church Cemetery 2/15 Pt. of Rocks, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701			
23. PART I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Malnutrition</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death 3-6 mos	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimers Disease</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D16675		29d. DATE SIGNED (Month, Day, Year) 2/14/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne Allgaier, MD 610 9th Avenue, Brunswick, Maryland 21716							
31. DATE FILED (Month, Day, Year) FEB 14 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06896

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Margaret Lewis				2. DATE OF DEATH MONTH DAY YEAR February 8, 1996		3. TIME OF DEATH 2:25 P. M.	
4. SOCIAL SECURITY NUMBER 217-16-2282		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 29, 1923	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 6115 Bartonsville Road		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6115 Bartonsville Road	
10f. ZIP CODE 21704				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mender		16b. KIND OF BUSINESS/INDUSTRY Textile	
17. FATHER'S NAME (First, Middle, Last) Frank Hooper, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy May Stultz			
19a. INFORMANT'S NAME (Type/Print) Brenda Harrison, daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5115 Shookstown Road Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. LOCATION — City or Town, State 2/12/96 Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. Douglas Stauffer</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Cancer of Pancreas</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Philip Shapiro, M.D.</i>		29c. LICENSE NUMBER D07186	
29d. DATE SIGNED (Month, Day, Year) 2/8/96				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip Shapiro, M.D. 814 Toll House Ave Frederick, Md 21702			
31. DATE FILED (Month, Day, Year) FEB 12 1996				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06897

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Medeiros Ladino				2. DATE OF DEATH MONTH DAY YEAR February 24, 1996		3. TIME OF DEATH 2:00 P.M.	
4. SOCIAL SECURITY NUMBER 281-03-4115		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 2, 1908	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) 8207 Edgewood Church Road		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 8207 Edgewood Church Road	
10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bio-chemist		16b. KIND OF BUSINESS/INDUSTRY U.S. Gov't/ Ft. Detrick	
17. FATHER'S NAME (First, Middle, Last) Louis M. Ladino				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Xavier			
19a. INFORMANT'S NAME (Type/Print) Michael Ladino				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10815 Fieldwood Dr., Fairfax, VA 22030			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 2/28		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Tane P. B. MacKay				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. cancer of prostate/ metastatic DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paget's Disease Arteriosclerotic coronary artery disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James A. Frizzell, M.D.				29c. LICENSE NUMBER D16637		29d. DATE SIGNED (Month, Day, Year) 2/26/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Frizzell, 915 Toll House Ave., Frederick, MD 21702							
31. DATE FILED (Month, Day, Year) FEB 27 1996				32. REGISTRAR'S SIGNATURE Richard R. Riddell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06898

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank Hedges LEWIS				2. DATE OF DEATH MONTH DAY YEAR February 22, 1996		3. TIME OF DEATH 11:10 am	
4. SOCIAL SECURITY NUMBER 220-18-2579		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 22, 1910	
9a. FACILITY NAME (If not institution, give street and number) 515 Fairview Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 515 Fairview Avenue				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher/Principal		16b. KIND OF BUSINESS/INDUSTRY Public Education			
17. FATHER'S NAME (First, Middle, Last) J Henry LEWIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida HEDGES			
19a. INFORMANT'S NAME (Type/Print) Francis X. Rhoads				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6596 East Lakeridge Road, New Market, MD 21774			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory Feb 23, 1996 Smithsburg, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith Lyman Robinson</i>		22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 E Church St. Frederick, MD 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary artery disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Mitral valve prolapse Carcinoma of prostate DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate Interval Between Onset and Death 5 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mitral valve prolapse Carcinoma of prostate							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Austin Pearre, Jr.</i>				29c. LICENSE NUMBER D09689		29d. DATE SIGNED (Month, Day, Year) February 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Austin Pearre, Jr, MD, 300 West Ninth Street, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) FEB 23 1996		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH:18 Rev. 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06900

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Franklin Mansfield, Jr.

2. Date of Death

Feb. 22 1996

3. Time of Death

5:15pm

4a. Facility Name (If not institution, give street and number)

3230 Beverley Drive

4b. City, Town, or Location of Death

Huntingtown

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

147 01 0732

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Sep 23, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3230 Beverley Drive

10f. Zip Code

20639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

plumber

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

John Franklin Mansfield, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Jones

19a. Informant's Name/Relationship (Type, Print)

William F. Mansfield / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

332 Wye Rd., Queenstown, MD 21658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stevensville Cemetery 2/26/96

Date

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, PA, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARCINOMA PROSTATE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-25435

29d. Date signed (Month, Day, Year)

2/23/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukesh Mathur, M.D. 110 Hospital Rd., Suite 305, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

FEB 27 1996

32. Registrar's Signature

J. Dawson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06901

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Arnett Manning

2. Date of Death

February 25, 1996

3. Time of Death

9 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8233 Bayside Rd.

4b. City, Town, or Location of Death

Chesapeake Beach

4c. County of Death

Calvert

5. Social Security Number

028 12 4046

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 8, 1925

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8233 Bayside Rd.

10f. Zip Code

20732

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

1 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Senior Designer

16b. Kind of Business/Industry

Ship Building

17. Father's Name (First, Middle, Last)

Roy Manning

18. Mother's Name (First, Middle, Maiden Surname)

Sara Neel

19a. Informant's Name/Relationship (Type, Print)

Mildred G. Manning/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 358, Chesapeake Beach, MD 20732

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

2-26-96

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *metastatic malignant melanoma*
Due to (or as a consequence of)Approximate
Interval Between
Onset and Death

6 mo

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D16823

29d. Date signed (Month, Day, Year)

2-26-96

30. Name and address of person who completed cause of death (If from 23a) (Type, Print)

RJ Schlager md 110 Hospital Dr #204 Pr Fred. Md 20678

31. Date filed (Month, Day, Year)

FEB 27 1996

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Elsie Mae Maugans		2. Date of Death Month Feb Day 27 Year 1996		3. Time of Death 2045	
4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or Location of Death Hagerstown,		4c. County of Death Washington	
5. Social Security Number 186-16-5981 214 10 7176		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86	
8. Date of Birth (Month, Day, Year) Sept. 5, 1909		9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown,	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 14014 Marsh Pike		10f. Zip Code 21740	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Joseph Madison Dallas	
18. Mother's Name (First, Middle, Maiden Surname) Elenda L. Thompson		19a. Informant's Name/Relationship (Type, Print) Frank Rosenberry		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12424 Indian Springs Rd. Clear Spring, MD.	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State Smithsburg, MD	
21. Signature of Funeral Service Licensee Michael J. Nease		22. Name and Address of Facility Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD. 21722		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory Failure Pneumonia Cerebrovascular Accident	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) Feb 28, 1996		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Michael J. Nease MD		29c. License number D18019	
29d. Date signed (Month, Day, Year) FEB 28, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA 334 MILL ST HAGERSTOWN MD 21740		31. Date filed (Month, Day, Year) FEB 28, 1996	
32. Registrar's Signature John D. [Signature]					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06903

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH X MN MOORE

2. Date of Death

February 24 1996

Day

Year

3. Time of Death

19:35

4a. Facility Name (If not institution, give street and number)

WASHINGTON CO HOSPITAL

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

412-46-5686

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 2, 1934

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

34 Hump Road

10f. Zip Code

21741

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

construction worker

16b. Kind of Business/Industry

glass mfg.

17. Father's Name (First, Middle, Last)

Mack Moore

18. Mother's Name (First, Middle, Maiden Surname)

Zella Carrier

19a. Informant's Name/Relationship (Type, Print)

Betty J. Moore

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1401, 34 Hump Rd., Hagerstown, Md. 21741

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

2-27-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

ABDOMINAL AORTIC ANEURYSM

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

043590

29d. Date signed (Month, Day, Year)

2-25-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN P. REED 22911 JEFFERSON BLVD SMITHSBURG MD 21783

31. Date filed (Month, Day, Year)

FEB 28 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


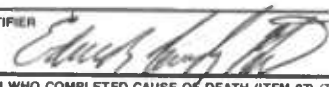

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 06904

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) MARY Beauford Miller				2. DATE OF DEATH MONTH 2 DAY 25 YEAR 96		3. TIME OF DEATH 12 Noon	
4. SOCIAL SECURITY NUMBER 214-09-2496		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 18, 1896	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH WASHINGTON			
9a. FACILITY NAME (If not institution, give street and number) CLEARVIEW NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN		9c. COUNTY OF DEATH WASHINGTON	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10804 DOWNSVILLE PIKE				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER & OPERATOR		15b. KIND OF BUSINESS/INDUSTRY RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) ORVEY O. MOSER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CORINDA MAE BANKS			
19a. INFORMANT'S NAME (Type/Print) GERALD O. MILLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10804 DOWNSVILLE PIKE, HAGERSTOWN, MD 21740			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BOONSBORO CEMETERY 2/28/96		20c. LOCATION — City or Town, State BOONSBORO, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Paul M. Dean				22. NAME AND ADDRESS OF FACILITY BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Bronchitis DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Brain Syndrome with Dementia Dehydration Inanition							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D07859		29d. DATE SIGNED (Month, Day, Year) 2-26-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Edson B. Moody 1190 Mt. Aetna Road, Hagerstown, MD 21740							
31. DATE FILED (Month, Day, Year) FEB 27 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06905

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edwin Eugene Munson, Sr.				2. Date of Death Month February Day 23 Year 1996		3. Time of Death 2244	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 219-20-0686	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 18, 1926	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Washington	10c. City, Town or Location Hagerstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1742 Edgewood Hills Circle			10f. Zip Code 21740		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) driver		16b. Kind of Business/Industry trucking			
	17. Father's Name (First, Middle, Last) Hiram Munson			18. Mother's Name (First, Middle, Maiden Surname) Stella Ramsey				
	19a. Informant's Name/Relationship (Type, Print) Mary Lee Munson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 1742 Edgewood Hills Circle Hagerstown, Maryland				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 2/26	20c. Location - City or Town, State Hagerstown, Maryland		
	21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>		22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Hagerstown, Md. 21740					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pneumonia Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death Weeks	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe chronic Obstructive Pulmonary Disease Acute respiratory Failure						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier <i>Denny MD</i>		29c. License number D41786		29d. Date signed (Month, Day, Year) 2/24/96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aleuchery MD 12821 Oak Hill Avenue, Hagerstown MD 21740								
31. Date filed (Month, Day, Year) FEB 26 1996								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06906

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH SARAH				2. DATE OF DEATH MONTH February DAY 20 YEAR 1996				3. TIME OF DEATH 1300 M	
4. SOCIAL SECURITY NUMBER 222-09-0808		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 9/3/08	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 223 Dove St.				10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursery Worker				16b. KIND OF BUSINESS/INDUSTRY Landscape Nursery	
17. FATHER'S NAME (First, Middle, Last) Ernest Washington Morris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma L. Niblett					
19a. INFORMANT'S NAME (Type/Print) Chester Parker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Dove St. Salisbury, MD 21801					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Cemetery		DATE 2/23/96		20c. LOCATION — City or Town, State Berlin, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. Burke Burbage</i>				22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams St. Berlin, MD 21811					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA AND UROSEPSIS DUE TO (OR AS A CONSEQUENCE OF): ADVANCED AGE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 1-2 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Fibrosis								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Burke Burbage MD</i>				29c. LICENSE NUMBER D39813	
29d. DATE SIGNED (Month, Day, Year) 2/20/96				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark W. 1104 Realthway Drive SALIS MD 21801					
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>Alia Davison-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06907

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) RAYMOND JOSEPH MULLEN				2. DATE OF DEATH MONTH DAY YEAR February 12, 1996		3. TIME OF DEATH 12:55 P.M.	
4. SOCIAL SECURITY NUMBER 056-26-5572		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 14, 1930	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) 490 Hillcrest Drive		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland			
10b. COUNTY Frederick				10c. CITY, TOWN OR LOCATION Frederick			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 490 Hillcrest Drive			
10f. ZIP CODE 21703				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951-1953		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supply Specialist		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Frank Mullen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Regina Bayard			
19a. INFORMANT'S NAME (Type/Print) Joan Dehler Mullen, wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 490 Hillcrest Drive Frederick, Maryland 21703			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest		20c. LOCATION — City or Town, State 2/15/96 Owings Mills, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic adenocarcinoma of the esophagus DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Deena J. Shapiro MD				29c. LICENSE NUMBER D35336		29d. DATE SIGNED (Month, Day, Year) 2/13/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10,810 Connecticut Avenue Kensington MD 20895 DEENA J. SHAPIRO							
31. DATE FILED (Month, Day, Year) FEB 14 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06908

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert McLaughlin				2. Date of Death Month Day Year February 24, 1996		3. Time of Death 2:35 P.M.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 032-14-0944	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 9, 1928		9. Birthplace (State or Foreign Country) Rhode Island	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 313 North Market Street Apt. #8			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician			16b. Kind of Business/Industry Nursing Home			
	17. Father's Name (First, Middle, Last) Joseph McLaughlin				18. Mother's Name (First, Middle, Maiden Surname) Unknown				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia M. McLaughlin (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 North Market St. Apt. #8 Frederick, MD 21701					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State 2/26 Smithsburg, Maryland				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer to Brain, Lung, Bone & Liver Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of certifier 		29c. License number 0-18191		29d. Date signed (Month, Day, Year) 2.24.96	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert E. Dailey & Son Funeral Homes, P.A. 1201 North Market St. Frederick, MD 21701									
31. Date filed (Month, Day, Year) FEB 26 1996				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

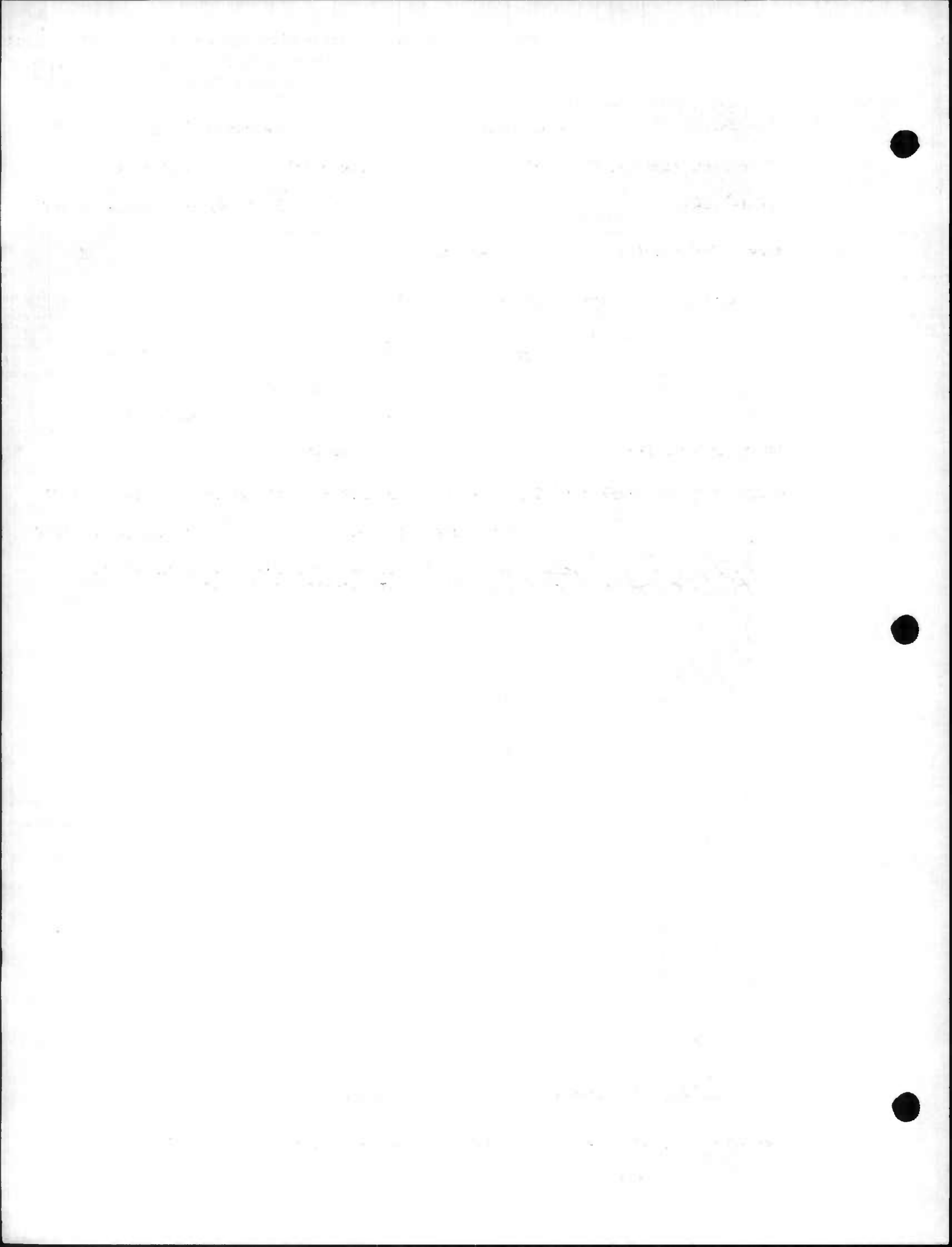
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patricia Elizabeth MOORE				2. DATE OF DEATH MONTH DAY YEAR February 21, 1996		3. TIME OF DEATH 5:10 pm	
4. SOCIAL SECURITY NUMBER 220-40-2353		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1941	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 36 South Market Street, Apt. 3		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 36 South Market Street, Apt. 3	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Samuel MOORE				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia BURGER			
19a. INFORMANT'S NAME (Type/Print) Mrs. Lisa A. Nicholson, Niece				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1132 Village Gate Drive, Mt. Airy, MD 21771			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place and date of disposition) Smithsburg Crematory, Feb. 23, 1996		20c. LOCATION — City or Town, State Smithsburg, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allan H Ruby		21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0703		22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carbon Monoxide Poisoning DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death Hours	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 2/21/96		28b. TIME OF INJURY 4:55 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED MALFUNCTION OF KEROSENE HEATER		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 36 S. MARKET FREDERICK			
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Andrew Zarick, Jr.				29c. LICENSE NUMBER D35164		29d. DATE SIGNED (Month, Day, Year) Feb 22, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Andrew Zarick, Jr., M.D., 130 Thomas Johnson Drive #5, Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) FEB 23 1996		32. REGISTRAR'S SIGNATURE Julia Swanson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06910

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Bell Mabrey				2. DATE OF DEATH MONTH DAY YEAR February 19, 1996				3. TIME OF DEATH 7:10 p m			
4. SOCIAL SECURITY NUMBER 221-22-6606		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) December 28, 1908		8. BIRTHPLACE (State or Foreign Country) Sudlersville					
9a. FACILITY NAME (If not institution, give street and number) 609 Bolton Woods Road (AT HOME)				9b. CITY, TOWN OR LOCATION OF DEATH Sudlersville			9c. COUNTY OF DEATH Queen Annes				
10a. STATE Maryland			10b. COUNTY Queen Annes		10c. CITY, TOWN OR LOCATION Sudlersville			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 609 Bolton Woods Road				10f. ZIP CODE 21668		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Luggage Assembler		16b. KIND OF BUSINESS/INDUSTRY Luggage Manufacturer							
17. FATHER'S NAME (First, Middle, Last) Harry Walls				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Luff							
19a. INFORMANT'S NAME (Type/Print) Audrey Burris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Bolton Woods Road, Sudlersville, Maryland 21668							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Sudlersville Cemetery/February 23, 1996			20c. LOCATION — City or Town, State Sudlersville, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENEE <i>Chas. B. Fellows</i>				22. NAME AND ADDRESS OF FACILITY Fellows, Helfenbein, & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. END-STAGE ALZHEIMER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 24 hr. 2 wk. 70 yrs.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MYOCARDIAL INFARCTION CONGESTIVE HEART FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Helen A. Noble MD</i>		29c. LICENSE NUMBER D41587		29d. DATE SIGNED (Month, Day, Year) 2-23-96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Helen A. Noble MD, Speer Road, Chestertown, MD											
31. DATE FILED (Month, Day, Year) FEB 23 '96				32. REGISTRAR'S SIGNATURE <i>Jana Davidson-Rendell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


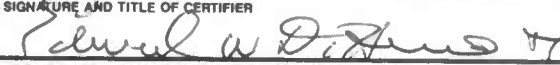

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 06911

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JANIS ARLINGTON POFFENBERGER				2. DATE OF DEATH MONTH DAY YEAR February 27, 1996		3. TIME OF DEATH 9:30 P M	
4. SOCIAL SECURITY NUMBER 217-56-1298		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 1 1912	
8a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		8c. COUNTY OF DEATH Washington	
10a. STATE Md.				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 201 Emmert Road				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Her own home			
17. FATHER'S NAME (First, Middle, Last) Marvin Leroy Kaniper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Odellia Clowes			
19a. INFORMANT'S NAME (Type/Print) Richard Poffenberger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Emmert Road Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) River View Cemetery 3-1-96		20c. LOCATION — City or Town, State Williamsport, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): b. and Arteriosclerotic Cardio Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 years years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D01062		29d. DATE SIGNED (Month, Day, Year) March 1, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 21740							
31. DATE FILED (Month, Day, Year) MAR - 4 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

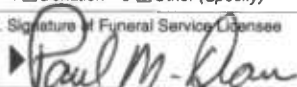
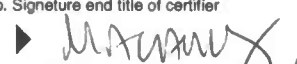

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06912

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TIFFANY LYNN PALMER				2. Date of Death Month Day Year FEBRUARY 27, 1996		3. Time of Death 12:45 AM													
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death													
Funeral Director	5. Social Security Number 218-45-4941	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 3 Months 4 Days	8. Date of Birth (Month, Day, Year) NOV. 23, 1995	9. Birthplace (State or Foreign Country) MARYLAND															
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County WASHINGTON	10c. City, Town or Location HAGERSTOWN			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
	10e. Street and Number 26 NORTH COLONIAL DRIVE			10f. Zip Code 21742		10g. Citizen of What Country? U.S.A.														
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NEVER EMPLOYED		16b. Kind of Business/Industry N/A															
	17. Father's Name (First, Middle, Last) DAVID E. PALMER				18. Mother's Name (First, Middle, Maiden Surname) MICHELLE LYNN KEEDY															
	19a. Informant's Name/Relationship (Type, Print) MICHELLE L. PALMER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 N. COLONIAL DR., HAGERSTOWN, MD 21742																
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		Date 3/1/96		20c. Location - City or Town, State BOONSBORO, MARYLAND													
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Paul M. Dean BAST FUNERAL HOME		7606 Old National Pike Boonsboro, Maryland 21713															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Renal failure</td> <td>Approximate Interval Between Onset and Death 1 day</td> </tr> <tr> <td>b.</td> <td>Liver failure</td> <td>4 weeks</td> </tr> <tr> <td>c.</td> <td>Prematurity</td> <td>3 months</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Renal failure	Approximate Interval Between Onset and Death 1 day	b.	Liver failure	4 weeks	c.	Prematurity	3 months	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Renal failure	Approximate Interval Between Onset and Death 1 day																	
	b.	Liver failure	4 weeks																	
	c.	Prematurity	3 months																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No														
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number N2092		29d. Date signed (Month, Day, Year) Feb 27, 1996														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bob Macauley, mo 600 N. Wolfe Street Baltimore, MD																				
31. Date filed (Month, Day, Year) MAR - 1 1996		32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06913

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Oryzine Pugliese				2. DATE OF DEATH MONTH DAY YEAR February 14, 1996		3. TIME OF DEATH 2:30 AM	
4. SOCIAL SECURITY NUMBER 577-09-1406		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 30, 1915	
9a. FACILITY NAME (If not institution, give street and number) 5762 Box Elder Ct.				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5762 Box Elder Ct				10f. ZIP CODE 21703		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson		16b. KIND OF BUSINESS/INDUSTRY Retail Merchandise			
17. FATHER'S NAME (First, Middle, Last) Michael Artie Clark				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Jane Runion			
19a. INFORMANT'S NAME (Type/Print) Diana L. Griffith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Gillis Rd., Woodbine, MD 21797			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 2/17/96		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ryan M. Berger</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>prob. h-tm metastases</i> 1 week							
b. <i>Transitional cell ca bladder</i> 6 mo							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D14625		29d. DATE SIGNED (Month, Day, Year) 4/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Gregory Rausch, MD 501 W. 7th Street, Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) FEB 16 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

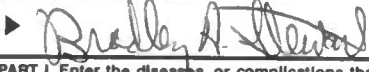

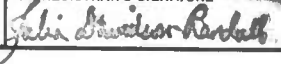
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06914

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lydia PETERSHEIM				2. DATE OF DEATH MONTH DAY YEAR February 23, 1996				3. TIME OF DEATH 1:30 A	
4. SOCIAL SECURITY NUMBER 215-56-9122		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) June 30, 1906				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 132 Sunny Valley Lane				9b. CITY, TOWN OR LOCATION OF DEATH Oakland				9c. COUNTY OF DEATH Garrett	
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 132 Sunny Valley Lane				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Christian B. Zook				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lovina Brennehan					
19a. INFORMANT'S NAME (Type/Print) Mildred Yoder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 Sunny Valley Lane, Oakland, MD 21550					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Slaubaugh Cemetery				20c. LOCATION — City or Town, State 2/26 Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1989	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Tachyarrhythmia								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Margaret A. Kaiser, M.D.				29c. LICENSE NUMBER D26650		29d. DATE SIGNED (Month, Day, Year) 2/23/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret A. Kaiser, M.D. PO Box 486 Oakland MD 21550									
31. DATE FILED (Month, Day, Year) FEB 26 1996				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06915

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Homer Landale Paugh				2. DATE OF DEATH MONTH DAY YEAR Feb 17 1996		3. TIME OF DEATH 9:30 a m	
4. SOCIAL SECURITY NUMBER 217 01 4280		5. SEX t <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct 17 1912		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) Garrett Co Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Swanton		10d. INSIDE CITY LIMITS? t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt1 Box 282				10f. ZIP CODE 21561		10g. CITIZEN OF WHAT COUNTRY? Usa	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coal Miner		16b. KIND OF BUSINESS/INDUSTRY Coal			
17. FATHER'S NAME (First, Middle, Last) John Paugh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary McNair			
19a. INFORMANT'S NAME (Type/Print) Opel Michaels				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt Lake Park, Md 21550			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, city, town or rural route number, state) Mt. Zion Cemetery Feb 20		20c. LOCATION — City or Town, State 96 Mt. Zion Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock				22. NAME AND ADDRESS OF FACILITY David A. Burdock Funeral Home PO Box 523 Kitzmiller, Md 21538			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert A. Goralski				29c. LICENSE NUMBER D23979		29d. DATE SIGNED (Month, Day, Year) 2/19/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert A. Goralski 311 N 4th St. Oakland, Md 21550							
31. DATE FILED (Month, Day, Year) FEB 20 1996				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06916

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN ALBERT PHEOBUS SR.				2. Date of Death Month Day Year FEBRUARY 19, 1996		3. Time of Death 7:20AM				
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK				
Funeral Director	5. Social Security Number 722-12-3866		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 2, 1909		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland			10b. County Frederick		10c. City, Town or Location Mount Airy			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 13704 Penn Shop Road				10f. Zip Code 21771		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Signal Maintenance			16b. Kind of Business/Industry Railroad				
17. Father's Name (First, Middle, Last) George Albert Pheobus					18. Mother's Name (First, Middle, Maiden Surname) Martha Hiltz						
19a. Informant's Name/Relationship (Type, Print) Naudine H. Pheobus - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13704 Penn Shop Road, Mount Airy, Maryland 21771						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		Date 2/23		20c. Location - City or Town, State Mount Airy, Maryland				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries complicated by Due to (or as a consequence of): b. Hypertensive Arteriosclerosis Due to (or as a consequence of): c. Cardiovascular Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 2/14/1996		28b. Time of Injury 12:37P ^M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVER IN AUTO/AUTO IMPACT 28e. Location (Street and Number or Rural Route Number, City or Town, State, Zip Code) PENN SHOP ROAD & RIDGE ROAD MT. AIRY, MARYLAND		
28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY											
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 20, 1996				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) FEB 21 1996					32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

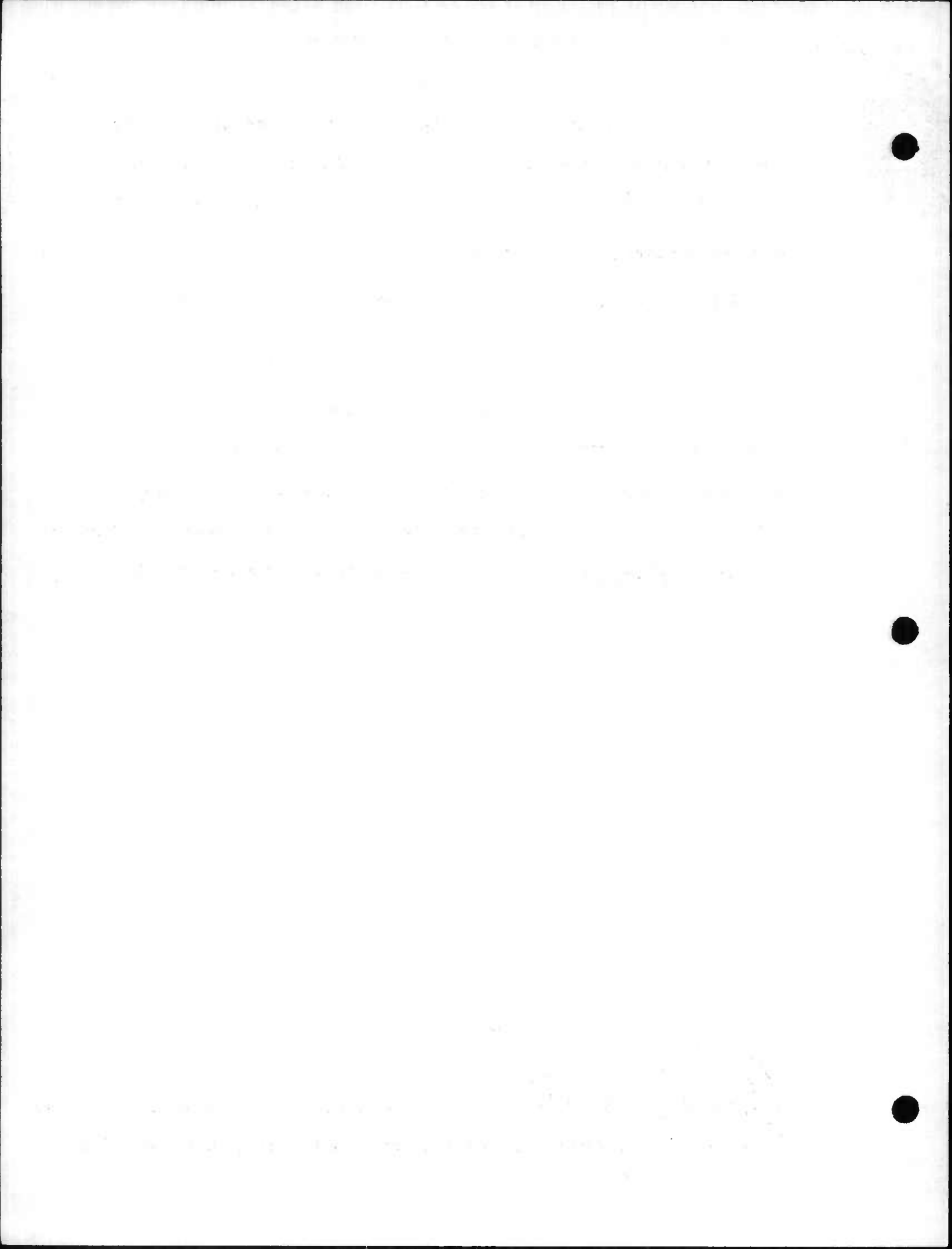
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06917

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR ELWOOD RUGGLES

2. Date of Death

February 22 1996

3. Time of Death

0605 AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

224-12-2188

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 29, 1920

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

100 GROVE LANE

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER & OPERATOR

16b. Kind of Business/Industry

JEWELRY STORE

17. Father's Name (First, Middle, Last)

WILLIAM W. RUGGLES

18. Mother's Name (First, Middle, Maiden Surname)

ANNA WINE

19a. Informant's Name/Relationship (Type, Print)

PATRICIA D. RUGGLES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 GROVE LANE, BOONSBORO, MARYLAND 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOONSBORO CEMETERY

Date

2/22/96

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike
Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

b. Chronic obstructive lung disease

Due to (or as a consequence of):

c. Status post right upper lobectomy

Due to (or as a consequence of):

d. for carcinoma of lung

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-12444

29d. Date signed (Month, Day, Year)

2-22-1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Eric M. Wagshal 1799 Howell Road, Hagerstown, Maryland 21740

31. Date filed (Month, Day, Year)

FEB 23 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten notes at the top of the page, including a date and some illegible text.

Main body of handwritten text, consisting of several lines of cursive script.

Bottom section of handwritten text, possibly a conclusion or signature block.

96 06918

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Thomas Yale Robertson</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Feb. 14 1996</i>		3. TIME OF DEATH <i>4:25 A M</i>	
4. SOCIAL SECURITY NUMBER <i>220-05-6478</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 1, 1915</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Brunswick</i>				9a. FACILITY NAME (If not institution, give street and number) <i>2939 Frye Road</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Jefferson</i>	
9c. COUNTY OF DEATH <i>Frederick</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Frederick</i>	
10c. CITY, TOWN OR LOCATION <i>Brunswick</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>315 East Potomac Street</i>	
10f. ZIP CODE <i>21716</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>WILL</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>Brakeman</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Brakeman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>B&O Railroad</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Charles Robertson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Many Genieve Foster</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Alan Robertson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3518 Chick Lane, Knoxville, MD 21758</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Park Heights Cemetery</i>		20c. LOCATION — City or Town, State <i>Brunswick, MD</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara A. Williams, Owner</i>				22. NAME AND ADDRESS OF FACILITY <i>John T. Williams Funeral Home 100 Petersville Rd., Brunswick, MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic lymphocytic leukemia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>6 mo</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes, hyper-calcaemia</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D14625</i>		29d. DATE SIGNED (Month, Day, Year) <i>Feb 16/96</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gregory P. Rausch, 501 W 7th St., Frederick, MD</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 21 1996</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06919

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Catherine Riggs				2. DATE OF DEATH MONTH February DAY 8 YEAR 1996		3. TIME OF DEATH 11:47 A M	
4. SOCIAL SECURITY NUMBER 215-26-8237		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 23, 1928	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Monrovia				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3531 Clarksburg Rd.	
10f. ZIP CODE 21770				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own home	
17. FATHER'S NAME (First, Middle, Last) Ray Hilton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Iva M. Watkins			
19a. INFORMANT'S NAME (Type/Print) Julie M. Frum				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3637 Kempton Church Rd., Monrovia, Md. 21770			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Providence Meth. Cemetery 2/12/96		20c. LOCATION — City or Town, State Kempton, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Oliver L. Molesworth</i>				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of the Pancreas DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur G. Manalo, M.D.</i>	
29c. LICENSE NUMBER 0-18191				29d. DATE SIGNED (Month, Day, Year) Feb. 9, 1996		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur G. Manalo, M.D. 11801 Fingerboard Rd., Monrovia, Md. 21770	
31. DATE FILED (Month, Day, Year) FEB 12 1996				32. REGISTRAR'S SIGNATURE <i>Pauline R. Ruffalo</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and compares them with the results of previous studies. It also discusses the implications of the findings for the field of study.

4. The fourth part of the report is a conclusion and a summary of the main findings of the study. It also includes a list of references and an appendix containing additional data and figures.

5. The fifth part of the report is a list of references and an appendix containing additional data and figures. It also includes a list of references and an appendix containing additional data and figures.

6. The sixth part of the report is a list of references and an appendix containing additional data and figures. It also includes a list of references and an appendix containing additional data and figures.

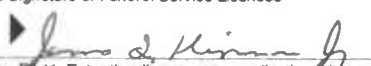
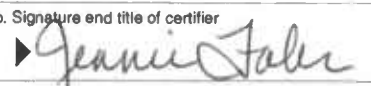
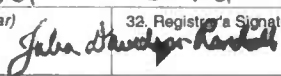
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06920

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Rizzi				2. Date of Death Month February Day 26 Year 1996		3. Time of Death 0140	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-52-8787		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 26, 1947	
	9. Birthplace (State or Foreign Country) District of Columbia		10e. State Md		10b. County Somerset		10c. City, Town or Location Princess Anne	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 31635 Mitchell Road		10f. Zip Code 21853		10g. Citizen of What Country? U.S.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Account Specialist		16b. Kind of Business/Industry General Electric			
	17. Father's Name (First, Middle, Last) Charles Davis				18. Mother's Name (First, Middle, Maiden Surname) Virginia Louise Green			
	19e. Informant's Name/Relationship (Type, Print) Anthony J. Rizzi, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31635 Mitchell Rd., Pr. Anne, Md. 21853			
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 2/29/96 Salisbury, Maryland			
	21. Signature of Funeral Service Licensee  M00295		22. Name and Address of Facility Hinman Funeral Home Princess Anne, Maryland 21853					
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Embolism Due to (or as a consequence of): b. Gastric cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 15mins Dx 2/21/96			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  MD		29c. License number		29d. Date signed (Month, Day, Year) Feb 26, 1996			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennie Faber Sinai Hospital Baltimore MD 21215							
	31. Date filed (Month, Day, Year) FEB 27 1996		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06921

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Everett Arthur Sharp				2. Date of Death Month Day Year February 24, 1996		3. Time of Death 1943	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 426 20 8133	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 25, 1918		9. Birthplace (State or Foreign Country) Mississippi
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location North Beach			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 3631 7th Street			10f. Zip Code 20714		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-41		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steamfitter		16b. Kind of Business/Industry construction		
	17. Father's Name (First, Middle, Last) William D. Sharp				18. Mother's Name (First, Middle, Maiden Surname) Minnie Huff			
	19a. Informant's Name/Relationship (Type, Print) Charles R. Pennifill				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 2/27/96		20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee William R. Huff				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Respiratory failure Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. pneumonia Due to (or as a consequence of): d. Cerebral vascular accident							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. Davidson-Randall				29c. License number D37588		29d. Date signed (Month, Day, Year) 2-26-96		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAFIK A. NASR MD - 135 W. Dares Beach Rd #109 Prince Frederick Md 20678								
31. Date filed (Month, Day, Year) FEB 27 1996		32. Registrar's Signature J. Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06922

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alta May SHIRLEY				2. DATE OF DEATH MONTH February DAY 25, YEAR 1996		3. TIME OF DEATH 9:15 a.m. M	
4. SOCIAL SECURITY NUMBER 217-30-5998		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 1 1932	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Avalon Manor Home, Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Funkstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 202 East				10f. ZIP CODE 21734		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		15b. KIND OF BUSINESS/INDUSTRY Her own home			
17. FATHER'S NAME (First, Middle, Last) Virgil Brother Peck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Pearl Bridendolph			
19a. INFORMANT'S NAME (Type/Print) Cynthia A. Shirley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 Crescent Road Hagerstown, Maryland 21742			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Church of God Cem. 2-28-96		20c. LOCATION — City or Town, State Clear Spring, Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. <i>Acute Myocardial Infarction</i>							<i>to mch</i>
b. <i>Anterior wall Myocardial Infarction</i>							<i>24</i>
c. _____							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus Chronic Phase</i> <i>hypertension</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>State MD</i>				29c. LICENSE NUMBER D18019		29d. DATE SIGNED (Month, Day, Year) Feb 26, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA MD 334 MILL ST HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) FEB 28 1996		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

108
108

96 06923

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAUDE SHOCKLEY				2. DATE OF DEATH MONTH 2 DAY 25 YEAR 96		3. TIME OF DEATH 8:30 A M	
4. SOCIAL SECURITY NUMBER 216-40-4637		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-16-04	
9a. FACILITY NAME (If not institution, give street and number) Snow Hill Nursing & Rehab.Center, Snow Hill				9b. CITY, TOWN OR LOCATION OF DEATH Snow Hill		9c. COUNTY OF DEATH Maryland	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Snow Hill		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6647 Whiton Road				10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Ananias Burton Truitt				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Evans Truitt			
19a. INFORMANT'S NAME (Type/Print) Curtis E. Shockley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 Shockley Rd., Snow Hill, Md. 21863			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Meth. Cemetery		20c. LOCATION — City or Town, State Snow Hill, Md.		20d. DATE 2/27	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Patricia L. Dennis				22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home P.O. Box 87, Snow Hill, Md. 21863			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. FEW DAYS							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SENILE DEMENTIA, ANEMIA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dorothy C. Holzworth M.D.				29c. LICENSE NUMBER D 06241		29d. DATE SIGNED (Month, Day, Year) 2-25-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DOROTHY C. HOLZWORTH 203 SNOW ST. SNOW HILL, MD. 21863							
31. DATE FILED (Month, Day, Year) FEB 26 1996				32. REGISTRAR'S SIGNATURE John J. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06924

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JULIA ELIZABETH SITTNER				2. DATE OF DEATH MONTH Feb. DAY 17 , 1996 YEAR				3. TIME OF DEATH 1:55 a. m.	
4. SOCIAL SECURITY NUMBER 213-74-0329		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 104 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 23, 1891		9. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 830 Dunbrooke Court				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) College			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk			16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) John Kiggins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Fitzgerald					
19a. INFORMANT'S NAME (Type/Print) Mr. Kenneth E. Coonley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Dunbrooke Court Frederick, Maryland 21701					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Schenectady Mem. Park		DATE 2/23		20c. LOCATION — City or Town, State Rotterdam, N.Y.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 10 years years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D26516		29d. DATE SIGNED (Month, Day, Year) Feb. 17, 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALLEN J. GILSON, MD 1475 Taney Ave. Frederick, Md. 21701									
31. DATE FILED (Month, Day, Year) FEB 21 1996		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


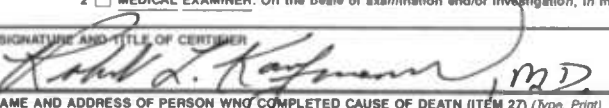

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06925

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET HELEN STIMMEL				2. DATE OF DEATH MONTH DAY YEAR Feb. 14, 1996				3. TIME OF DEATH 9:28 A M					
4. SOCIAL SECURITY NUMBER 220-03-3904		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 30, 1923		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) Citizens Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick					
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 115 Water Street				10f. ZIP CODE 21788				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY None					
17. FATHER'S NAME (First, Middle, Last) William Brice						18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Devilbiss							
19a. INFORMANT'S NAME (Type/Print) Dorsey R. Stimmel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Gallorette Court, Walkersville, Maryland 21793									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Blue Ridge Cemetery 2/17				20c. LOCATION — City or Town, State Thurmont, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788									
23. PART I. Enter the diseases, or complications that caused his death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Hepatic Insufficiency</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death <u>3 mos</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>No</u>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  MD						29c. LICENSE NUMBER D13971		29d. DATE SIGNED (Month, Day, Year) 2/16/96					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert L. Kaufmann, MD 300 West Ninth Street, Frederick, Maryland 21701													
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06926

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willard Anderson Sigler				2. Date of Death Month February Day 14 Year 1996		3. Time of Death 11:35 AM			
	4a. Facility Name (If not Institution, give street and number) Fredenick Memorial Hospital				4b. City, Town, or Location of Death Fredenick		4c. County of Death Fredenick			
Funeral Director	5. Social Security Number 217-30-721		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar 25, 1935	9. Birthplace (State or Foreign Country) W. Va.		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Fredenick		10c. City, Town or Location Brunswick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1 Terrace Avenue				10f. Zip Code 21716		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) 9 Elementary/Secondary (0-12) Collage (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Canman			16b. Kind of Business/Industry Railroad			
	17. Father's Name (First, Middle, Last) Julius Vincent Sigler				18. Mother's Name (First, Middle, Maiden Surname) Lottie Mae Lucas					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bentha E. Sigler - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Terrace Avenue - Brunswick, MD 21716					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagenstown Crematory		20c. Location - City or Town, State 1116 Hagenstown, MD					
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner		22. Name and Address of Facility John T. Williams Funeral Home Brunswick, MD 21716							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hyperkalemia Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of): DIABETES mellitus Due to (or as a consequence of):								Approximate Interval Between Onset and Death hrs Yrs	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN Peripheral Vascular Disease										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mark P. Rubin								
29c. License number D29592		29d. Date signed (Month, Day, Year) 2/15/96								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK P. RUBIN 56 Thomas Johnson Dr FREDERICK MD 21702										
31. Date filed (Month, Day, Year) FEB 16 1996		32. Registrar's Signature John Davidson Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

96 06927

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GILBERT MAX SCHUCHT				2. DATE OF DEATH MONTH DAY YEAR Feb. 12, 1996		3. TIME OF DEATH 8:30 P M	
4. SOCIAL SECURITY NUMBER 396-26-5988		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 16, 1904	
8. BIRTHPLACE (State or Foreign Country) Wisconsin				9a. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
9b. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home				RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1001 Carroll Parkway #320				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Scientist		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Max Schucht				18. MOTHER'S NAME (First, Middle, Maiden Surname) Adeline Gross			
19a. INFORMANT'S NAME (Type/Print) Gladys B. Schucht				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Carroll Parkway #320, Frederick, MD 21701			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 2/14		20c. LOCATION — City or Town, State Smithsburg, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Dailey</i>	
22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death 2 months 3 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's Disease, mitral Regurgitation</i> <i>COPD</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mary P. Howell MD</i>				29c. LICENSE NUMBER D46075		29d. DATE SIGNED (Month, Day, Year) 2/14/1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary Howell MD 915 Toll House Avenue, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>William R. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06928

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Louise Shane

2. Date of Death

Month Day Year
February 9, 1996

3. Time of Death

5:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

220-28-7710

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 26, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8237 Black Haw Court

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Government Employee

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Charles Edward Schill

18. Mother's Name (First, Middle, Maiden Surname)

Rosealine Masser

19a. Informant's Name/Relationship (Type, Print)

Debra Greenwell (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8237 Black Haw Court, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Springs Cemetery

Date

2/13

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST. FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Rheumatic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 hrs

40 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D07186

29d. Date signed (Month, Day, Year)

2/10/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Shapiro, MD 814 Toll House Avenue, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

FEB 12 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06929

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Howard Stone			2. Date of Death Month Day Year February 9, 1996		3. Time of Death 11:50PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 218-34-3556		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 9, 1905
	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 6939 North Clifton Road			10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Agriculture	
	17. Father's Name (First, Middle, Last) Harry G. STONE			18. Mother's Name (First, Middle, Maiden Surname) Carrie BRANDENBURG			
	19a. Informant's Name/Relationship (Type, Print) Grace R. Stone, Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6939 North Clifton Road, Frederick, MD 21702			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Feb.13,1996		20c. Location - City or Town, State Frederick, Maryland		
	21. Signature of Funeral Service Licensee ▶ Allan H Ruby MO0703			22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Approximate Interval Between Onset and Death 8 YEARS							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier ▶ John A. Vitarello M.D.		29c. License number D27544	29d. Date signed (Month, Day, Year) 2/10/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John A. Vitarello, M.D., 300 West Ninth Street, Frederick, MD 21701						
	31. Date filed (Month, Day, Year) FEB 12 1996		32. Registrar's Signature ▶ [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06930

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Francis Sobeck

2. Date of Death

Month Day Year
February 20, 1996

3. Time of Death

12:14 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

170-22-7510

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 13, 1929

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

8505 Chestnut Grove Road

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manufacturing Engineer

18b. Kind of Business/Industry

Air and Space Industry

17. Father's Name (First, Middle, Last)

Francis P. Sobeck

18. Mother's Name (First, Middle, Maiden Surname)

Jannette Dietz

19a. Informant's Name/Relationship (Type, Print)

Christine Weaver, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 McClellan Drive East Berlin, Pennsylvania 17316

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Gardens

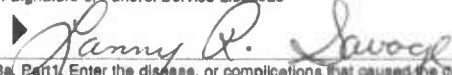
Date

2/21/96

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRO VASCULAR ACCIDENT.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROSIS

Due to (or as a consequence of):

YEARS

c. HYPERTENSION ESSENTIAL

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NA

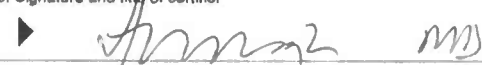
28f. Location (Street and Number or Rural Route Number, City or Town, State)

NA

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-18063

29d. Date signed (Month, Day, Year)

2/20/96

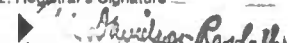
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Abdul Majeed 801 Toll House Ave. Frederick, MD

31. Date filed (Month, Day, Year)

FEB 22 1996

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

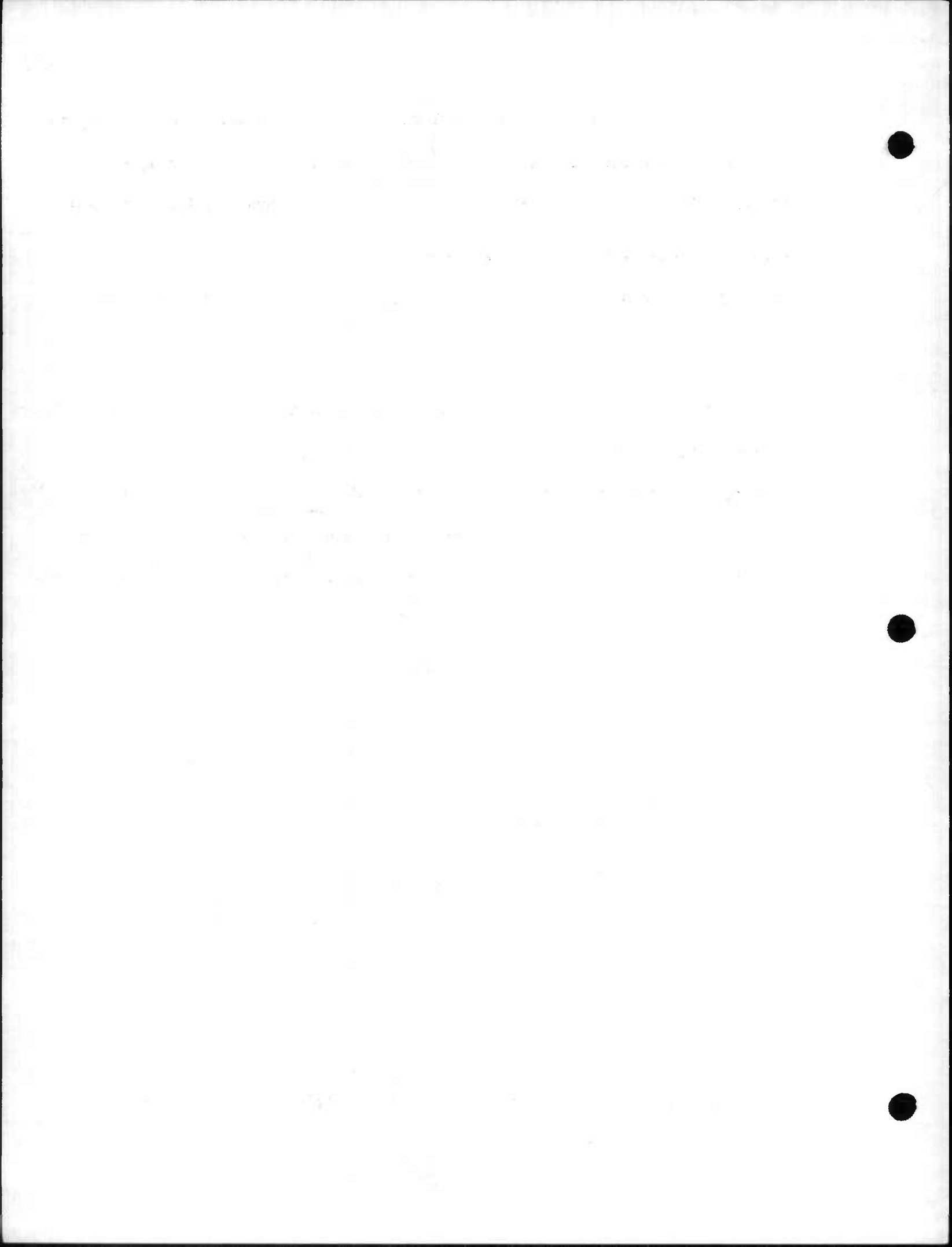
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director




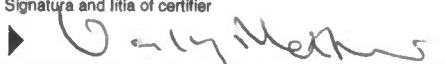
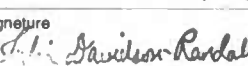
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06931

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leslie Onis Thomas				2. Date of Death Month February Day 19 Year 1996		3. Time of Death 1245		
	4e. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 513-10-2270		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 5, 1915		
	9. Birthplace (State or Foreign Country) Missouri		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Holland Point		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 820 Bayfront Avenue		10f. Zip Code 20714		
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supply manager				16b. Kind of Business/Industry Civil Service				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Dolpha Thomas				18. Mother's Name (First, Middle, Maiden Surname) Stella Clark				
	19a. Informant's Name/Relationship (Type, Print) Mrs. Martha L. Thomas / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Feb 23, 1996 Suitland, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DECOMPENSATED HEART FAILURE Due to (or as a consequence of): RUPTURED ABDOMINAL AORTIC ANEURYSM Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 3 hrs 6 hrs	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined							28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M							28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred							28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier 	
To Be Completed by Physician/Medical Examiner	29c. License number 245435							29d. Date signed (Month, Day, Year) 2/19/96	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARKET MATHEW CALVERT MEMORIAL HOSPITAL							31. Date filed (Month, Day, Year) 2/19/96 FEB 27 1996	
State Registrar	32. Registrar's Signature 							33. Date of Death February 19, 1996	
	34. Date of Death February 19, 1996							35. Date of Death February 19, 1996	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06932

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nora Belle TIMMONS				2. Date of Death Month Feb Day 22 Year 1996		3. Time of Death 7:31	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 565-78-0923		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) June 11 1949	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14703 Falling Waters Road		10f. Zip Code 21795		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1-10 College (1-4 or 5+) 0		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner-Operator		16b. Kind of Business/Industry Cleaning Service			
	17. Father's Name (First, Middle, Last) Walter Jackson Kidd				18. Mother's Name (First, Middle, Maiden Surname) Anna Catherine Ferrell			
	19a. Informant's Name/Relationship (Type, Print) Larry L. Timmons, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14703 Falling Waters Rd. Williamsport, Md. 21795			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery 2-26-96		20c. Location - City or Town, State Hagerstown, Maryland			
	21. Signature of Funeral Service Licensee Scott M. Minnick		22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21795					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sudden Cardiac Death Due to (or as a consequence of): Hypercholesterolemia Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier William W. Gallagher, MD		29c. License number D31880		29d. Date signed (Month, Day, Year) 2/22/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William W. Gallagher, MD 1110 Medical Campus Rd, Hagerstown								
31. Date filed (Month, Day, Year) FEB 27 1996								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06933

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCES J. TRADER				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21 1996		3. TIME OF DEATH 5:26 P M	
4. SOCIAL SECURITY NUMBER 213-22-8946		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/14/1903	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Worcester			
10a. FACILITY NAME (If not institution, give street and number) Berlin Nursing Home				10b. CITY, TOWN OR LOCATION OF DEATH Berlin		10c. COUNTY OF DEATH Worcester	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STATE Maryland				10f. COUNTY Worcester		10g. CITY, TOWN OR LOCATION Berlin	
10h. STREET AND NUMBER 108 Bryan Avenue				10i. ZIP CODE 21811		10j. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk & Home Care Provider		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Henry Mills Dryden				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret V. Long			
19a. INFORMANT'S NAME (Type/Print) Ethel M. Mariner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 East Federal St., Snow Hill, Md. 21863			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Salem Methodist Cemetery 2/25		20c. LOCATION — City or Town, State Pocomoke City, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott S. Melson</i>				22. NAME AND ADDRESS OF FACILITY Melson Funeral Home PO Box 64, Pocomoke City, Md. 21851			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Generalized Atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 6 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Essential Hypertension</i> <i>Fracture of the Pelvis</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Bellosa M.D.</i>				29c. LICENSE NUMBER D29505		29d. DATE SIGNED (Month, Day, Year) 2-22-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO BELLOSO MD 4421 BEECHWOOD PL. CRISFIELD MD 21817							
31. DATE FILED (Month, Day, Year) FEB 26 1996				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06934

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES OTIS TAYLOR				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 19, 1996		3. TIME OF DEATH 2219 M	
4. SOCIAL SECURITY NUMBER 218-05-1873		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-1-12	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION GirdleTree		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5904 Taylor Landing Rd.				10f. ZIP CODE 21829		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory		16b. KIND OF BUSINESS/INDUSTRY Poultry			
17. FATHER'S NAME (First, Middle, Last) Dallas Taylor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Collick			
19a. INFORMANT'S NAME (Type/Print) ANNA M. Wharton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Taylor Landing Rd. GirdleTree, MD. 21829			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) COUSPRING 2-19-96 GirdleTree, MD.		20c. LOCATION — City or Town, State MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Keith E. Wharton				22. NAME AND ADDRESS OF FACILITY Wharton FH 22171 Wharton Rd. Accomac, VA 23334			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Congestive & Sudden Death Minutes					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Alcohol & Congestive Heart Failure Hours					
		c. 					
		d. 					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Cerebral Vascular Accident							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> HOME <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER John G. Green				29c. LICENSE NUMBER 002020		29d. DATE SIGNED (Month, Day, Year) 2/13	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John G. Green 2414 W. LOCUST STS. SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE John G. Green			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06935

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel H. Taylor				2. DATE OF DEATH MONTH DAY YEAR Feb. 13 1996		3. TIME OF DEATH 5 a M	
4. SOCIAL SECURITY NUMBER 579-14-5613		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 7 1921	
8. BIRTHPLACE (State or Foreign Country) Florida				9. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital		10. CITY, TOWN OR LOCATION OF DEATH Olney	
11. COUNTY OF DEATH Montgomery				12. STATE MD		13. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
14. STREET AND NUMBER 101 Carlisle Street				15. ZIP CODE 20904		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: white	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		23. KIND OF BUSINESS/INDUSTRY Homemaking			
24. FATHER'S NAME (First, Middle, Last) Bertram Heflebower				25. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Mildred Mora			
26. INFORMANT'S NAME (Type/Print) Joseph L Yates				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15824 Barnesville Rd. Boyds, MD 20841			
28. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg 2/14		30. LOCATION — City or Town, State Smithsburg, MD		31. SIGNATURE OF FUNERAL SERVICE LICENSEE William C. Kilt	
32. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Barnesville, MD 20838		33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOsclerotic occlusion of Aorta DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOsclerotic Peripheral Vase Disease DUE TO (OR AS A CONSEQUENCE OF): c. ARTERIOsclerotic Coronary Vase Disease DUE TO (OR AS A CONSEQUENCE OF): d. Generalized Arteriosclerosis Approximate Interval Between Onset and Death 2 days years years year					
34. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arterio Sclerotic Disease, CVA, COPD, Rheumatoid Arthritis, Recurrent UTI						35. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
36. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						37. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
38. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
40. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		41. DATE OF INJURY (Month, Day, Year)		42. TIME OF INJURY M		43. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		45. DESCRIBE HOW INJURY OCCURRED					
46. LOCATION (Street and Number or Rural Route Number, City or Town, State)		47. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
48. SIGNATURE AND TITLE OF CERTIFIER Oliver J. Lawrence MD				49. LICENSE NUMBER D25410		50. DATE SIGNED (Month, Day, Year) 13/February/96	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. O. J. Lawrence 3807 International Drive Silver Spring MD							
52. DATE FILED (Month, Day, Year) FEB 21 1996				53. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06936

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD GERRET <u>GERRIT</u> VANDERVALK, II		2. Date of Death Month Day Year FEB. 18, 1996		3. Time of Death 10:00 AM.	
	4a. Facility Name (If not institution, give street and number) HYATTSTOWN MILL RD. RT. 121 & 355		4b. City, Town, or Location of Death CLARKSBURG		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 263-57-6548		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.	
	8. Date of Birth (Month, Day, Year) April 1, 1959		9. Birthplace (State or Foreign Country) Florida			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Monrovia	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12422 Fingerboard Road		10f. Zip Code 21770	
	10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1977	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Land Surveyor		16b. Kind of Business/Industry Surveying	
	17. Father's Name (First, Middle, Last) Edward Gerrit Vandervalk		18. Mother's Name (First, Middle, Maiden Surname) Isabel Reay			
	19a. Informant's Name/Relationship (Type, Print) Tammy Vadervalk - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12422 Fingerboard Road, Monrovia, Maryland 21770			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MongomeryCrematoriumInc. 2/21/96		20c. Location - City or Town, State Bethesda, Maryland.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypothermia complicated by Drowning Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) CREEK		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 2-18-95		28b. Time of Injury 10 00 M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Found in Creek		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Creek		
28f. Location (Street and Number or Rural Route Number, City or Town, State) Hyattstown Mill Rd Rt 121		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEB. 19, 1996		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201		
31. Date filed (Month, Day, Year) FEB 23 1996		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06937

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED E. WRIGHT				2. Date of Death Month 2 Day 27 Year 96		3. Time of Death 7³⁰ AM	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 183-12-2045		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 4-8-1920	
	9. Birthplace (State or Foreign Country) Arendtsville, Pa.		10a. State MD.		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 622 Salem Ave.				10f. Zip Code 21740		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Domestic			
	17. Father's Name (First, Middle, Last) Evers L. Knipple				18. Mother's Name (First, Middle, Maiden Surname) Sarah Jane Wilkinson			
	19a. Informant's Name/Relationship (Type, Print) Kenneth J. Wright				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4313 Dixie Ave. Chambersburg, Pa. 17201			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Gardens		20c. Location - City or Town, State Chambersburg, Pa.			
	21. Signature of Funeral Service Licensee Ernest S. Deal				22. Name and Address of Facility Thomas L. Geisel Funeral Home, Inc. 333 Falling Spring Rd. Chambersburg, Pa. 17201			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Mixed Mesodermal Tumor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 6 months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Michael J. McCormack M.D.		29c. License number 041667		29d. Date signed (Month, Day, Year) 2/27/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. McCormack 1799 Howell Road Hagerstown, MD. 21740							
State Registrar	31. Date filed (Month, Day, Year) MAR - 1 1996				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3cc

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 06938

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THELMA KATHERINE WINEBRENNER				2. Date of Death Month Day Year FEBRUARY 22 1996		3. Time of Death 10:50 P.M.	
	4e. Facility Name (If not institution, give street and number) Williamsport Nursing Home				4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-30-8974		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 4, 1907	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 154 North Artizan Street		10f. Zip Code 21795		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home			
	17. Father's Name (First, Middle, Last) Charles Lewis May		18. Mother's Name (First, Middle, Maiden Surname) Bessie Belle Mc Namee		19. Informant's Name/Relationship (Type, Print) Paul F. May			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery 02-26-96		Date Hagerstown, Maryland		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee R. Noel Brady		22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 E. Antietam St., Hagerstown, Md. 21740					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. URO SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. CACHEXIA Due to (or as a consequence of): c. CEREBRAL INFARCT Due to (or as a consequence of): d. CACHEXIA Due to (or as a consequence of):						Approximate Interval Between Onset and Death 48 HOURS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CACHEXIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier E. Howe MD					
State Registrar	29c. License number D33700		29d. Date signed (Month, Day, Year) February 25, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TED E. HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD. 21713			
	31. Date filed (Month, Day, Year) FEB 26 1996		32. Registrar's Signature J. H. [Signature]					

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a summary of the main findings of the study.

6. The sixth part is a list of the names of the authors and their institutions.

7. The seventh part is a list of the titles of the papers presented at the conference.

8. The eighth part is a list of the names of the speakers and their topics.

9. The ninth part is a list of the names of the organizers and their roles.

10. The tenth part is a list of the names of the sponsors and their contributions.

11. The eleventh part is a list of the names of the participants and their affiliations.

12. The twelfth part is a list of the names of the reviewers and their comments.

13. The thirteenth part is a list of the names of the editors and their responsibilities.

14. The fourteenth part is a list of the names of the publishers and their addresses.

15. The fifteenth part is a list of the names of the distributors and their locations.

16. The sixteenth part is a list of the names of the subscribers and their contact information.

17. The seventeenth part is a list of the names of the advertisers and their products.

18. The eighteenth part is a list of the names of the donors and their amounts.

19. The nineteenth part is a list of the names of the volunteers and their hours.

20. The twentieth part is a list of the names of the staff and their salaries.

21. The twenty-first part is a list of the names of the board members and their terms.

22. The twenty-second part is a list of the names of the committees and their chairs.

23. The twenty-third part is a list of the names of the advisory boards and their members.

24. The twenty-fourth part is a list of the names of the steering committees and their tasks.

25. The twenty-fifth part is a list of the names of the working groups and their reports.

26. The twenty-sixth part is a list of the names of the task forces and their findings.

27. The twenty-seventh part is a list of the names of the study groups and their conclusions.

28. The twenty-eighth part is a list of the names of the research teams and their projects.

29. The twenty-ninth part is a list of the names of the research centers and their facilities.

30. The thirtieth part is a list of the names of the research institutes and their achievements.

96 06939

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NANCY WATERS				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 14 1996		3. TIME OF DEATH 12:40 P M	
4. SOCIAL SECURITY NUMBER 126-30-8089		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 26, 1913	
9a. FACILITY NAME (If not institution, give street and number) Berlin Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Berlin, Md.		9c. COUNTY OF DEATH Worcester	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION 111 N. Ross St. - Snow Hill, Md.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 111 N. Ross St.				10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY House work	
17. FATHER'S NAME (First, Middle, Last) Alonzo Waters				18. MOTHER'S NAME (First, Middle, Maiden Surname) Flonie Parker			
19a. INFORMANT'S NAME (Type/Print) Frances Ames				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 N. Ross St. Snow Hill, Md. 21863			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Coolspring		DATE 2-19-96		20c. LOCATION — City or Town, State Girdletree, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Keith E. Wharton				22. NAME AND ADDRESS OF FACILITY Wharton & Accomac, Va. 23301			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Due to (or as a consequence of): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
29. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D46257		29d. DATE SIGNED (Month, Day, Year) 2/14/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDWIN CASTANEDA, MD 314 FRANKLIN AVE. SUITE 103 BERLIN MD 21811							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06940

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN JACOB WEISKOPF				2. DATE OF DEATH MONTH DAY YEAR Feb. 15, 1996		3. TIME OF DEATH 12:00 P M	
4. SOCIAL SECURITY NUMBER 159-14-3092		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 1, 1920	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 5688 Barberry Court		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5688 Barberry Court	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Budget Analyst		16b. KIND OF BUSINESS/INDUSTRY Veterans Administration	
17. FATHER'S NAME (First, Middle, Last) Jacob Joseph Weiskopf				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Murphy			
19a. INFORMANT'S NAME (Type/Print) Marie E. Weiskopf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5688 Barberry Court, Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepatosoma DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Underlying Cause of Death DUE TO (OR AS A CONSEQUENCE OF): Hepatosoma DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Founding, Asides, Venues							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30496 Md.		29d. DATE SIGNED (Month, Day, Year) 2/16/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis E. Becker, MD 300 West Ninth Street, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) FEB 23 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06941

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HIRAM A. WOLFE				2. DATE OF DEATH MONTH DAY YEAR Feb. 6, 1996		3. TIME OF DEATH 12:40 P.M.	
4. SOCIAL SECURITY NUMBER 216-14-5574		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 19, 1922	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 7010 Old Pryor Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Thurmont	
9c. COUNTY OF DEATH Frederick							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7010 Old Pryor Rd.				10f. ZIP CODE 21788		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942 to 1964		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 3 Master Sergeant		16b. KIND OF BUSINESS/INDUSTRY U.S. Army			
17. FATHER'S NAME (First, Middle, Last) Hampton M. Wolfe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Smith			
19a. INFORMANT'S NAME (Type/Print) Thelma Salvi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9237 Waynesboro Rd., Emmitsburg, MD 21788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Blue Ridge Cemetery 2/9		20c. LOCATION — City or Town, State Thurmont, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Robert E. Dailey & Son Funeral Homes, P.A. 615 E. Main St., Thurmont, MD 21788			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic Lymphoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 6 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D36147		29d. DATE SIGNED (Month, Day, Year) Feb. 7, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1030 Fairfield Rd Gettysburg, PA 17325							
31. DATE FILED (Month, Day, Year) FEB 14 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06942

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARTIN L. WATERS				2. DATE OF DEATH MONTH DAY YEAR FEBRUARY 25 1996		3. TIME OF DEATH 0100	
4. SOCIAL SECURITY NUMBER 219-03-5848		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-21-1910	
8. BIRTHPLACE (State or Foreign Country) Md.				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Md		10b. COUNTY SOMERSSET	
10c. CITY, TOWN OR LOCATION Upper Fairmount				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P.O. Box 277	
10f. ZIP CODE 21867				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) LABORER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY SEAFOOD	
17. FATHER'S NAME (First, Middle, Last) DOWD WATERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNIE WATERS			
19a. INFORMANT'S NAME (Type/Print) AGNES WATERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 277 Upper Fairmount Md. 21867			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) WATERS CEMETERY 7/30/96 Upper Fairmount Md.		20c. LOCATION — City or Town, State Upper Fairmount Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Anthony E. Ward				22. NAME AND ADDRESS OF FACILITY 30639 Hampden Ave. Princess Anne Md. 21853			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease 30 years DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerosis 40 years DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, Chronic Nephro-sclerosis, Diabetes Mellitus II DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. L. M. Evangelista				29c. LICENSE NUMBER 1797670		29d. DATE SIGNED (Month, Day, Year) 2/25/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. L. M. Evangelista				31. DATE FILED (Month, Day, Year) FEB 27 1996			
32. REGISTRAR'S SIGNATURE John Anderson-Rodall				33. REGISTRAR'S NAME AND ADDRESS 105 Pine Bluff Rd #4 Salisbury, MD 21801			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6873813

96 06943

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>WILLIAM M. WASHINGTON</u>				2. DATE OF DEATH MONTH <u>FEB.</u> DAY <u>10</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>11:00a</u>	
4. SOCIAL SECURITY NUMBER <u>220-68-8311</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>40</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8-15-55</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>5606 Jefferson Hghts. Dr.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Capitol Hghtd., Md.</u>		9c. COUNTY OF DEATH <u>Prince George</u>	
10a. STATE <u>Md</u>				10b. COUNTY <u>Prince George</u>		10c. CITY, TOWN OR LOCATION <u>Capitol Heights</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>5606 Jefferson Heights Drive</u>			
10f. ZIP CODE <u>20743</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Truck Driver</u>		16b. KIND OF BUSINESS/INDUSTRY <u>DELIVERY</u>			
17. FATHER'S NAME (First, Middle, Last) <u>GRAFTON WILLIAMS</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Cassalins Washington</u>			
19a. INFORMANT'S NAME (Type/Print) <u>RUBY WASHINGTON</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1661 GOOD HOPE RD. S.E. WASH., D.C. 20020</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>CENTENNIAL CEMETERY</u>		20c. LOCATION — City or Town, State <u>FAIRMONT, MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Clinton Layton</u>				22. NAME AND ADDRESS OF FACILITY <u>Robert G. Mason Funeral Home</u> <u>1661 Good Hope Rd. S.E. Wash, DC 20020</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hepatocellular Carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u></u> DUE TO (OR AS A CONSEQUENCE OF): c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u></u>		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <u></u>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u></u>					
29. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u></u>							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>John L. Marshall</u>				29c. LICENSE NUMBER <u>19655 DC</u>		29d. DATE SIGNED (Month, Day, Year) <u>2/13/96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John L. Marshall, MD 3800 Reservoir Rd. N.W. Wash, DC 20007</u>							
31. DATE FILED (Month, Day, Year) <u>FEB 27 1996</u>				32. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06944

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM EUGENE WRIGHT, JR.						2. Date of Death Month Day Year Feb 22 1996		3. Time of Death 1252am	
	4a. Facility Name (If not institution, give street and number) 199 Newburg Avenue						4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-09-1422		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Oct 16, 1917		9. Birthplace (State or Foreign Country) Brunswick	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 199 Newburg Avenue				10f. Zip Code 21228		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> Collage (1-4or 5+) <input type="checkbox"/>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Block Operator			16b. Kind of Business/Industry Conrail		
	17. Father's Name (First, Middle, Last) William Eugene Wright, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Mabel Inene Peannell			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marian Wright						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199 Newburg Avenue, Catonsville, MD 21228			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Park Heights		20c. Location - City or Town, State 2/24 Brunswick, MD					
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner						22. Name and Address of Facility John I. Williams Funeral Home 100 Petersville Rd., Brunswick MD 21716			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastasis of Transitional Cell Carcinoma Due to (or as a consequence of): b. Right Renal Transitional Cell Carcinoma Due to (or as a consequence of): c. Recent ureter stents Due to (or as a consequence of): d. Indwelling Foley catheter									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Normal Pressure hydrocephalus Indwelling ventriculo-peritoneal shunt Hypertension										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Gregory L. Taylor MD		29c. License number DZ7556		29d. Date signed (Month, Day, Year) 2/24/96				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory L. Taylor MD 720 Maiden Choice Lane Ste B Balt, MD										
31. Date filed (Month, Day, Year) FEB 26 1996		32. Registrar's Signature Jackie Randall								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

96 06945

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN VIRGINIA WALKER				2. DATE OF DEATH Feb. 20, 1996		3. TIME OF DEATH 2:15 A M	
4. SOCIAL SECURITY NUMBER 216-38-5979		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 9, 1912	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER Meridian Nursing Center 400 North Avenue	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY None	
17. FATHER'S NAME (First, Middle, Last) Albert Duvall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae Justice			
19a. INFORMANT'S NAME (Type/Print) Raymond W. Walker Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13324 Catocin Furnace Rd., Thurmont, MD 21788			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Jennings Chapel Cemetery 2/23		20c. LOCATION — City or Town, State Florence, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Dailey</i>				22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES</u> <u>ASHD.</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julio Menocal</i>				29c. LICENSE NUMBER D 31912		29d. DATE SIGNED (Month, Day, Year) 2/20/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julio Menocal, MD 1564 Opossumtown Pike, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 06946					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Helen Elizabeth WASTLER				2. DATE OF DEATH February 19, 1996				3. TIME OF DEATH 8:00 AM					
4. SOCIAL SECURITY NUMBER 218-50-3378		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH April 10, 1906		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not Institution, give street and number) 106 Frederick Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick					
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 106 Frederick Avenue				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Edgar Gordon NULL				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie May HILTNER									
19a. INFORMANT'S NAME (Type/Print) Mr. Carl R. Wastler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Frederick Avenue, Frederick, Maryland 21701									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Mount Olivet Cemetery, Feb. 21, 1996		DATE Feb. 21, 1996		20c. LOCATION — City or Town, State Frederick, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. [Signature] M00255				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchopneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death 5 days 1 yr			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D 14626				29d. DATE SIGNED (Month, Day, Year) Feb. 19, 1996					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. P. Gregory Rausch MD 501 West Seventh Street, Frederick, Maryland 21701													
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE John [Signature]									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06947

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Viola Yeakle

2. Date of Death

February 27, 1996

3. Time of Death

2335

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

220-26-5273

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/3/1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

13726 Blairvalley Road

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Residence

17. Father's Name (First, Middle, Last)

Harold Ernest French

18. Mother's Name (First, Middle, Maiden Surname)

Grace Louise McCauley

19a. Informant's Name/Relationship (Type, Print)

Robert E. Yeakle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13726 Blairvalley RD. Clear Spring, MD 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Blairvalley Cem. 3/1/1996 Clear Spring, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thompson Funeral Home, Inc.
P.O. Box 310 Clear Spring, MD 21722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe obstructive pulmonary disease, End Stage 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

800041

29d. Date signed (Month, Day, Year)

2-18-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ER 2001204R 380 Park Cleveland Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

FEB 29 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06948

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lena ----- Yoder				2. DATE OF DEATH MONTH DAY YEAR February 12, 1996				3. TIME OF DEATH 1:00 A M	
4. SOCIAL SECURITY NUMBER 212-78-4582		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Mar. 8, 1926				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland				9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4106 Mason School Road				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Simon D. Swartzentruber				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy ----- Yoder					
19a. INFORMANT'S NAME (Type/Print) John C. Yoder				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Mason School Road, Oakland, Maryland 21550					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Slaubaugh Cemetery 2/14				20c. LOCATION — City or Town, State Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Bradley H. Howard</i>				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Colon Carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death Weeks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. John Porcaro</i>				29c. LICENSE NUMBER D29313				29d. DATE SIGNED (Month, Day, Year) ► 2/13/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. John Porcaro, MD 311 N. Fourth St., Oakland, Maryland 21550									
31. DATE FILED (Month, Day, Year) FEB 26 1996				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06949

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Theodore Hazel Young				2. DATE OF DEATH MONTH DAY YEAR Feb. 18 1996		3. TIME OF DEATH 12:02a^M	
4. SOCIAL SECURITY NUMBER 214-12-7843		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 30 1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE MD			
10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Dickerson			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 22111 Dickerson School Road			
10f. ZIP CODE 20842				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman		16b. KIND OF BUSINESS/INDUSTRY Park & Planning			
17. FATHER'S NAME (First, Middle, Last) Lester Shaw Young				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Hickman			
19a. INFORMANT'S NAME (Type/Print) William Poole				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17329 Hughes Rd. Poolesville, MD 20837			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Monocacy		20c. LOCATION — City or Town, State 2/20 Beallsville, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Barnesville, MD 20838		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Stroke DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary embolus Brain Trauma						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 026660		29d. DATE SIGNED (Month, Day, Year) 2/20/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. Raphaelson 801 Toll House Ave. Frederick, Md. 21701							
31. DATE FILED (Month, Day, Year) FEB 21 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06950

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred NMN ZIMMERMAN				2. Date of Death Month Day Year 2/23/96		3. Time of Death 0244	
	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-28-7164		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 19, 1908	
	9. Birthplace (State or Foreign Country) West Virginia		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Washington 10c. City, Town or Location: Hagerstown 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Street and Number 1424 Hamilton Blvd.		12. Zip Code 21742	
13. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		14. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		16. Race - American Indian, Black, White, etc. Specify: white		
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 1-4		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Audiological Service school for the deaf		19. Kind of Business/Industry				
20. Father's Name (First, Middle, Last) James Sites				21. Mother's Name (First, Middle, Maiden Surname) Sue Ella Judy				
22. Informant's Name/Relationship (Type, Print) Mrs. Sue Green / niece				23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1144 Pinch Valley Road, Westminster, Maryland 21158				
24. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		25. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		26. Date 2-25-96		27. Location - City or Town, State Hagerstown, Maryland		
28. Signature of Funeral Service Licensee Scott M. Minnich				29. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740				
30. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) e. <u>Arteriosclerotic cardiovascular disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
31. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Same severe (Alzheimer's) Dementia</u> <u>Coronary artery disease</u>								
32. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
33. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
34. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
35. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		36. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
37. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		38a. Date of Injury (Month, Day, Year)		38b. Time of Injury M		38c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
38d. Describe how injury occurred		38e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		38f. Location (Street and Number or Rural Route Number, City or Town, State)				
39. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
40. Signature and title of certifier				41. License number D26806		42. Date signed (Month, Day, Year) 2/23/96		
43. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allan D. H. 747 North Ave Hagerstown MD 21742								
44. Date filed (Month, Day, Year) FEB 27 1996				45. Registrar's Signature				

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

96 06951

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Linda Mae Argo				2. DATE OF DEATH MONTH DAY YEAR March 9, 1996		3. TIME OF DEATH 1:50am	
4. SOCIAL SECURITY NUMBER 166-01-1720		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1910	
9a. FACILITY NAME (If not institution, give street and number) 2201 Southorn Road				9b. CITY, TOWN OR LOCATION OF DEATH 21220 -Middle River		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2201 Southorn Road				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) Thomas B. Enright				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Ratledge			
19a. INFORMANT'S NAME (Type/Print) Arlene Weber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Kingston Road Baltimore Md. 21220			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 3/11/96		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Maco Ave Baltimore Md 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure—List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Leiomyosarcoma DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER John G. Arple		29c. LICENSE NUMBER D11795	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7505 Oster Dr. Towson, Md. 21204				29d. DATE SIGNED (Month, Day, Year) 3/11/96			
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE John Arple					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06952

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,


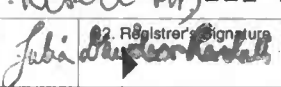
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) LINDA J. BARWICK		2. Date of Death Month FEB. Day 24 Year 1996		3. Time of Death 0615AM	
4a. Facility Name (If not institution, give street and number) 10 WOODED WAY		4b. City, Town, or Location of Death PIKESVILLE		4c. County of Death BALTIMORE	
5. Social Security Number 214-64-3284	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 2, 1953
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State Md.	10b. County Baltimore	10c. City, Town or Location Randallstown			
10e. Street and Number 3421 Barry Paul Road		10f. Zip Code 21133		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Jay W. Hamby			18. Mother's Name (First, Middle, Maiden Surname) Dolline Baugher		
19a. Informant's Name/Relationship (Type, Print) Jay W. Hamby		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Doris Ave., Baltimore, Md. 21225			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wards Chapel Church Cem.		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., ElkrIDGE, Md. 21227			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE DRUG INTOXICATION					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) MULTIPLE DRUG INTOXICATION					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MOTEL			
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND 2/24/96		28b. Time of Injury 5:00 A M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred SUBJECT INGESTED DRUGS	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT MOTEL		28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 WOODED WAY	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) FEBRUARY 24, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Kessler 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAR 12 1996		32. Registrar's Signature 			

State
Registrar

96-1069-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: 28e, 28f, PER MEO FILM G-73 State of Maryland / Department of Health and Mental Hygiene
3/12/96 t.t

Certificate of Death

Reg. No.

96 06953

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD LEE BAKER			2. Date of Death Month Day Year FEBRUARY 28, 1996		3. Time of Death 12:36 P.M.		
	4a. Facility Name (If not institution, give street and number) 895 HARBOR TUNNEL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-05-5505		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-23-20	
	9. Birthplace (State or Foreign Country) N. CAROLINA							
To Be Completed by Funeral Director	Usual Residence of Decedent			10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE			
	10e. Street and Number 524 N. CHARLES STREET APT. 1201			10f. Zip Code 21201		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MGMT.		16b. Kind of Business/Industry ESSKAY MEATS			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) UNKNOWN			18. Mother's Name (First, Middle, Maiden Surname) MAMMIE L. MOORE				
	19a. Informant's Name/Relationship (Type, Print) MR. ROBERT WETHERINGTON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5434 BUCKNELL ROAD BALTO. MD. 21206				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) 3-4 SACRED HEART OF JESUS CEM.		20c. Location - City or Town, State BALTO. CO. MD.			
	21. Signature of Funeral Service Licensee <i>Charles R. Kaczorowski</i>			22. Name and Address of Facility KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. MULTIPLE INJURIES ASSOCIATED WITH Due to (or as a consequence of): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 2/28/96		28b. Time of Injury 1206 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred 895 Harbor Tunnel Baltimore City, MD		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY				
		28f. Location (Street and Number or Rural Route Number, City or Town, State) I-895 EXIT 13 BALTIMORE CITY, MD.						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dennis J. Chute M.D.</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 29, 1996		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) MAR 12 1996		32. Registrar's Signature <i>John Davidson Randall</i>						

Baltimore, Maryland 21215-0020

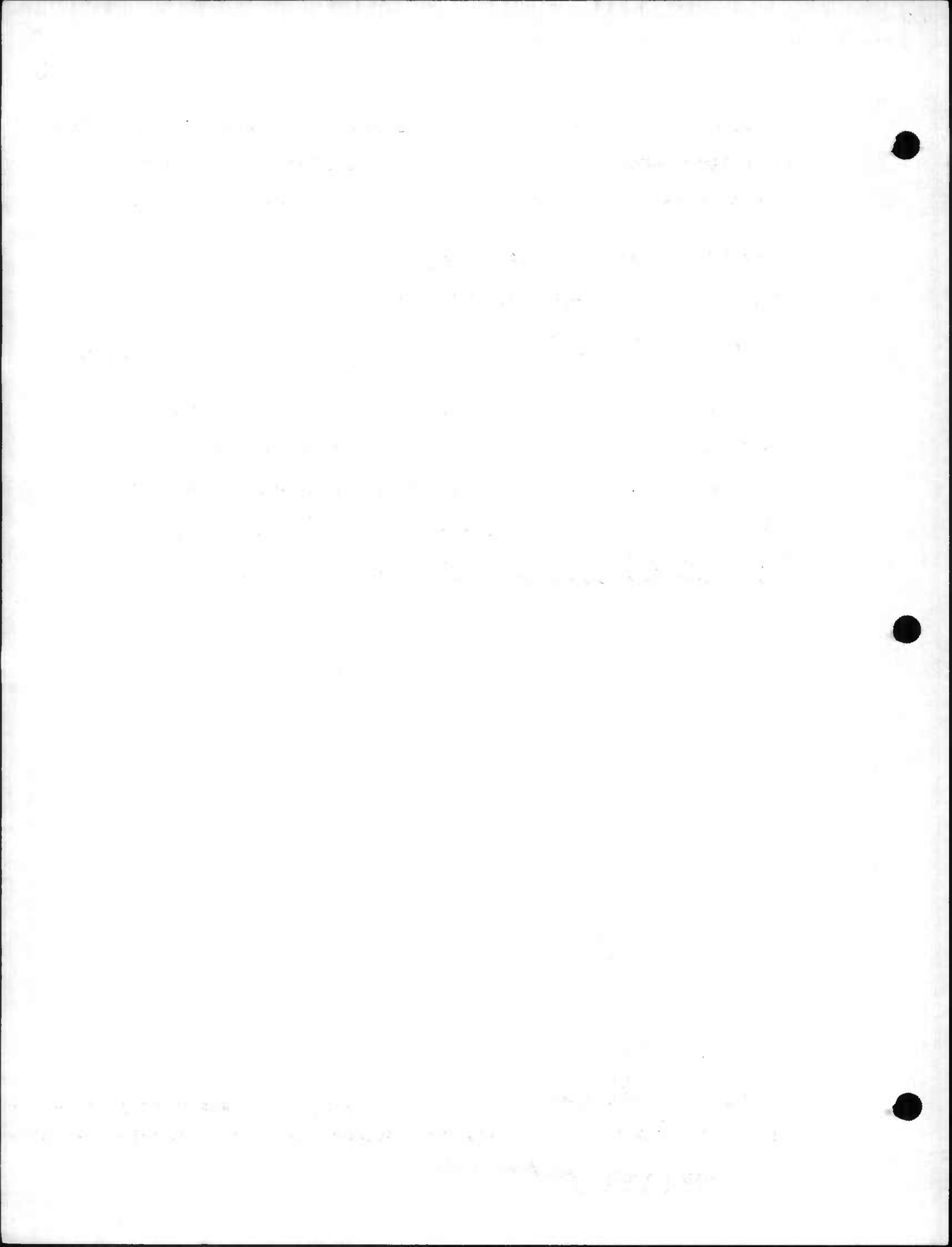
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Oscar Edward Beck, Jr.						2. DATE OF DEATH MONTH DAY YEAR March 10 1996		3. TIME OF DEATH HOURS MIN. SEC. 6:29 p.m.							
4. SOCIAL SECURITY NUMBER 219-30-0849		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH MONTH DAY YEAR September 22, 1932		8. BIRTHPLACE (State or Foreign Country) Maryland								
9a. FACILITY NAME (If not institution, give street and number) 5534 Whitwood Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A							
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 5534 Whitwood Road				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? United States									
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1952-1960		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housing Inspector		16b. KIND OF BUSINESS/INDUSTRY City Government											
17. FATHER'S NAME (First, Middle, Last) Oscar E. Beck, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madelyn R. Jackson											
19a. INFORMANT'S NAME (Type/Print) Mrs. Katrina C. Beck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5534 Whitwood Road Baltimore, Maryland 21206											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park 3/14/96		20c. LOCATION — City or Town, State Baltimore, Maryland											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavovyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PULMONARY FIBROSIS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 years															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE ISCHEMIC HEART DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER James H. Harrison MD				29c. LICENSE NUMBER 15561		29d. DATE SIGNED (Month, Day, Year) 3/11/96									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) JAMES BIDDISON MD 7401 OSTER DR, Baltimore 21204															
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE John Anderson-Karroll											

12+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06955

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALVIN HERBERT

2. Date of Death

Month
MARCHDay
8thYear
1996

3. Time of Death

0423 PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-26-3219

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
JUL 27, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

80 W Ewing Drive

10f. Zip Code

21136

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1959-1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (1-4 or 5+)
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

City Jail

17. Father's Name (First, Middle, Last)

Herbert Beverly

18. Mother's Name (First, Middle, Maiden Surname)

Robena Keene

19a. Informant's Name/Relationship (Type, Print)

Rosetta Beverly-Fortune

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

80 Ewing Drive, Reisterstown, MD 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem.

Date

3-12-96

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Bernard D Johnson

22. Name and Address of Facility

March Funeral Home
1101 E. North Avenue, Baltimore, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

e. Due to (or as a consequence of):

b. GASTROINTESTINAL BLEED

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

STROKE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Kwashi Attigbe, MEDICAL DOCTOR

29c. License number

P09306

29d. Date signed (Month, Day, Year)

MARCH 8th 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS KWASHI ATTIGBE GOOD SAMARITAN HOSP OF MARYLAND INC.

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completedly filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06956

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Redmond Boland

2. Date of Death
Month Day Year
March 10 1996

3. Time of Death
9:15 A.M.

4a. Facility Name (If not institution, give street and number)

Oak Crest Village

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

212-05-2649

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)
82 Yrs.

8. Date of Birth (Month, Day, Year)
November 2, 1913

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Blvd, Apt. 1203

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager - Production

16b. Kind of Business/Industry
Baltimore G. & E.

17. Father's Name (First, Middle, Last)

Michael J. Boland

18. Mother's Name (First, Middle, Maiden Surname)

Winifred J. Ellwood

19a. Informant's Name/Relationship (Type, Print)

Mrs. Gladys L. Boland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10e

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Grdns 3/13/96 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald E. Chisholm

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic colon ca*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Ruck, Staff Physician

29c. License number

D19714

29d. Date signed (Month, Day, Year)

3/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILYARK RUTEN JYOVML 4940 EASTERN AVE, BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

John D. ...

State Registrar

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

12+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06957

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Burrell Jeanette Y. Brooks</u>					2. Date of Death Month <u>March</u> Day <u>8</u> Year <u>1996</u>		3. Time of Death <u>10:10 P.M.</u>	
	4a. Facility Name (If not institution, give street and number) <u>2100 Mt Holly Street</u>					4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>NA</u>	
Funeral Director	5. Social Security Number <u>216-62-0853</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>42</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>NOV 23, 1953</u>		9. Birthplace (State or Foreign Country) <u>MD</u>
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>NA</u>	10c. City, Town or Location <u>21216</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <u>2100 Mt Holly Street</u>			10f. Zip Code <u>21216</u>		10g. Citizen of What Country? <u>U.S.A</u>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th grade</u> College (1-4 or 5+) <u>NA</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Aide</u>			16b. Kind of Business/Industry <u>Hospital</u>			
	17. Father's Name (First, Middle, Last) <u>Richard Stanley</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Shirley Burrell</u>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Shirley M. Christian Mother</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2100 Mt Holly Street Baltimore, MD 21216</u>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Arbutus Mem Park</u>		Date <u>3/12/96</u>		20c. Location - City or Town, State <u>Arbutus, MD</u>		
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>March F. H. West</u> <u>4300 Wabash Avenue Baltimore, MD</u>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic Breast Cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								<u>6 years</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <u>[Signature]</u>					29c. License number <u>D40854</u>		29d. Date signed (Month, Day, Year) <u>March 11, 1996</u>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>407-T 301 St. Paul Place Baltimore, MD 21202</u>									
31. Date filed (Month, Day, Year) <u>MAR 12 1996</u>		32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

96 06958

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH WEINTZWEIG BROTMAN		2. DATE OF DEATH MONTH MARCH DAY 9 YEAR 96		3. TIME OF DEATH 9:10 P.M.
4. SOCIAL SECURITY NUMBER 218-10-9472	5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	7. DATE OF BIRTH MONTH MAR DAY 25 YEAR 1918	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9. COUNTY OF DEATH BALTIMORE		
9a. FACILITY NAME (If not institution, give street and number) 2823 W. STRATHMORE AVE.		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2823 West S TRATHMORE AVE		
10f. ZIP CODE 21209		10g. CITIZEN OF WHAT COUNTRY? US		
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) (12) College (1-4 or 5+) HOUSEWIFE		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) Joseph Weintzweig		18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Bornstein		
19a. INFORMANT'S NAME (Type/Print) Benjamin Brozman		19b. MAILING ADDRESS 2823 W. Strathmore Ave Balto, MD. 21209		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK 3-11-1996- RANDALLSTOWN, MD		20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joel D Lewis		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEPATIC FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST METASTATIC CARCINOMA OF ESOPHAGUS				Approximate interval Between Onset and Death 1 DAY
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 3/9/96		28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER John A. Soder		29c. LICENSE NUMBER D10718		29d. DATE SIGNED (Month, Day, Year) 3/9/96
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARRY MAURICE WALLEN MD 40000 COURT RD, BALTO., 21208				
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE John A. Soder		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06959

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORIS E BELL				2. DATE OF DEATH MONTH DAY YEAR MARCH 7 1996		3. TIME OF DEATH 1912 M	
4. SOCIAL SECURITY NUMBER 228-22-1315		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 8, 1924	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9. COUNTY OF DEATH BALTIMORE CO.			
10. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				11. CITY, TOWN OR LOCATION OF DEATH N/A		12. COUNTY OF DEATH BALTIMORE CO.	
13. STATE MARYLAND		14. COUNTY BALTIMORE CO		15. CITY, TOWN OR LOCATION N/A		16. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
17. STREET AND NUMBER 7600 Clays Lane				18. ZIP CODE 21244		19. CITIZEN OF WHAT COUNTRY? U.S.A.	
20. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: BLACK	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 1 yr				25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		26. KIND OF BUSINESS/INDUSTRY ROSEWOOD STATE HOSPITAL	
27. FATHER'S NAME (First, Middle, Last) UNKNOW				28. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Bell			
29. INFORMANT'S NAME (Type/Print) Paul Robinson/Son				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 S. Carver St. Baltimore, Maryland 21215			
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery		33. DATE 3/15		34. LOCATION — City or Town, State BALTIMORE, MARYLAND	
35. SIGNATURE OF FUNERAL SERVICE LICENSEE Harri P. Close				36. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue			
37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA & UTI b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE, DM						39. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						41. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
42. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		43. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
44. 27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural 5. <input type="checkbox"/> Pending Investigation 2. <input type="checkbox"/> Accident 6. <input type="checkbox"/> Could not be determined 3. <input type="checkbox"/> Suicide 4. <input type="checkbox"/> Homicide		45. 28a. DATE OF INJURY (Month, Day, Year)		46. 28b. TIME OF INJURY M		47. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		48. 28d. DESCRIBE HOW INJURY OCCURRED		49. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		50. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
51. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
52. 29b. SIGNATURE AND TITLE OF CERTIFIER C. Ravi MD				53. 29c. LICENSE NUMBER D37333		54. 29d. DATE SIGNED (Month, Day, Year) MARCH 7, 1996	
55. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. RAVI MD NHC BALTO MD 21133							
56. 31. DATE FILED (Month, Day, Year) MAR 12 1996				57. 32. REGISTRAR'S SIGNATURE Jana Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06960

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET ANN BRENNAN

2. Date of Death

March 10 1996

Day Year

3. Time of Death

6:05 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

219-18-5239

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 16, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County
Harford

10c. City, Town or Location

Forest Hills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1402 Balsam Place

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Bernard Cecil Auer

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ward

19a. Informant's Name/Relationship (Type, Print)

James Anthony Brennan/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1308 Denby Road Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 03/11/96

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. OVARIAN CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY FIBROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kendall R. Faulkner

29c. License number

D25643

29d. Date signed (Month, Day, Year)

3/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 Dulaney Valley Road Towson, MD 21204

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

Julia Driscoll

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06961

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Garland Busch				2. Date of Death Month March Day 6 Year 1996		3. Time of Death 10:30 PM												
	4a. Facility Name (If not institution, give street and number) 1431 Kent Road				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore												
Funeral Director	5. Social Security Number 225-18-9924		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) July 14, 1921												
	9. Birthplace (State or Foreign Country) Kentucky		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex												
Usual Residence of Decedent																			
10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Essex													
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 1431 Kent Road			10f. Zip Code 21221													
10g. Citizen of What Country? U.S.A.			11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date WW II													
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)													
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Food Industry			17. Father's Name (First, Middle, Last) John D. Busch													
18. Mother's Name (First, Middle, Maiden Surname) Della Scott			19a. Informant's Name/Relationship (Type, Print) Carl Busch (SON)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1431 Kent Road Essex, Maryland 21221													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery March 11, 1996			20c. Location - City or Town, State Baltimore, CO.													
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Ave. Baltimore, MD. 21221																
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Bowel obstruction</td> <td rowspan="4"> Due to (or as a consequence of): b. Bladder Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td rowspan="4"> Approximate Interval Between Onset and Death 2 weeks 1 year </td> </tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Bowel obstruction	Due to (or as a consequence of): b. Bladder Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 2 weeks 1 year						
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Bowel obstruction	Due to (or as a consequence of): b. Bladder Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 2 weeks 1 year															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No												
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)													
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 			29c. License number D33624			29d. Date signed (Month, Day, Year) 3/7/96													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN C. DOWNS, M.D. 7505 OSLER DR STE 504, TOWSON, MD 21204																			
31. Date filed (Month, Day, Year) MAR 12 1996			32. Registrar's Signature 																

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06962

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daisy Bitzer

2. Date of Death

Month March 10, Day 1996 Year

3. Time of Death

8:10 PM

4a. Facility Name (If not institution, give street and number)

Ivy Hall Nursing Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

213-36-9385

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month July 16, Day 1911 Year

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1315 Fourth Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Glassmyer

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Nispol

19a. Informant's Name/Relationship (Type, Print)

Patricia E. Caldwell (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3711 Redgrove Rd., Middle River, MD. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Park

Date

3/14/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.
1407 Old Eastern Ave., Baltimore, MD. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 1 HOUR

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

~ 15 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERCALCEMIA DUE TO HYPERPARATHYROIDISM

SEVERE OSTEOPOROSIS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

DIS022

29d. Date signed (Month, Day, Year)

3/14/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

8552 PHILADELPHIA RD., BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1
Date: 10/10/10
Page 1 of 1

Page 1 of 1
Date: 10/10/10
Page 1 of 1

Page 1 of 1
Date: 10/10/10
Page 1 of 1

Page 1 of 1
Date: 10/10/10
Page 1 of 1

96 06963

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Olive W. Battistone</u>				2. DATE OF DEATH MONTH <u>MAR</u> DAY <u>9</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>1200 P</u> M	
4. SOCIAL SECURITY NUMBER <u>579-14-3316</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Feb. 19, 1916</u>	
8. FACILITY NAME (If not institution, give street and number) <u>Lorien Nursing Home</u>				9. CITY, TOWN OR LOCATION OF DEATH <u>Columbia</u>		10. BIRTHPLACE (State or Foreign Country) <u>Washington, DC</u>	
11. RESIDENCE OF DECEDENT				12. COUNTY OF DEATH <u>Howard</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. STATE <u>MD</u>		15. COUNTY <u>Montgomery</u>		16. CITY, TOWN OR LOCATION <u>Kensington</u>		17. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
18. STREET AND NUMBER <u>4218 McCain Court</u>				19. ZIP CODE <u>20895</u>		20. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>None</u>		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		27. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>			
28. FATHER'S NAME (First, Middle, Last) <u>William Howard McKnight</u>				29. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Olive Marie Barnett</u>			
30. INFORMANT'S NAME (Type/Print) <u>Linda M. Leber (Daughter)</u>				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5471 Delphinium Court, Columbia, MD 21045</u>			
32. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		34. DATE <u>11, 1996</u>		35. LOCATION — City or Town, State <u>Catonsville, MD</u>	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				37. NAME AND ADDRESS OF FACILITY <u>Leroy M & Russell C Witzke Funeral Home</u> <u>5555 Twin Knolls Rd. Columbia, MD 21045</u>			
38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Adenocarcinoma (lung)</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Emphysema</u> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <u>Arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				41. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		42. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
43. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		44. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
45. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		46. DATE OF INJURY (Month, Day, Year)		47. TIME OF INJURY <u>M</u>		48. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		49. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		50. DESCRIBE HOW INJURY OCCURRED			
51. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		52. SIGNATURE AND TITLE OF CERTIFIER		53. LICENSE NUMBER <u>BD 4610 475</u>		54. DATE SIGNED (Month, Day, Year) <u>10 MAR 96</u>	
55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>James Day 11055 Little Patuxent Parkway Columbia MD</u>							
56. DATE FILED (Month, Day, Year) <u>MAR 12 1996</u>		57. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06964

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Elizabeth Brown				2. DATE OF DEATH MONTH March DAY 8 YEAR 1996		3. TIME OF DEATH 9:15 A M	
4. SOCIAL SECURITY NUMBER 219-18-2001		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 5 1925	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Lawrence Road 7534		9b. CITY, TOWN OR LOCATION OF DEATH Dundalk	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Lawrence Road 7534	
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home maker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Melvin Staniewicz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Olenski			
19a. INFORMANT'S NAME (Type/Print) Philip Brown Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Rd. 7534 Dundalk, Maryland 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Mary March 11		20c. LOCATION — City or Town, State Dundalk, Maryland		20d. OATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mash A. Chojnacki</i>				22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., MD. 21224			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial infarction a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema, atherosclerosis							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bernard J. Yukna</i>				29c. LICENSE NUMBER P14206		29d. DATE SIGNED (Month, Day, Year) 03-08-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bernard J. Yukna MD. 59 Dundalk Ave. Dundalk, Maryland 21222							
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE <i>J. H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3/12/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

Reg. No.

96 06965

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BILLY JUNIOR CRIBBS CRIBBS JR.				2. Date of Death Month Day Year MARCH 3, 1996		3. Time of Death 1:05PM																																				
	4e. Facility Name (If not institution, give street and number) 1011 NORTH AUGUSTA AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A																																				
Funeral Director	5. Social Security Number 241-52-0106		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) July 10, 1936																																				
	Usual Residence of Decedent		10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE																																				
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1011 N. Augusta Avenue		10f. Zip Code 21229		10g. Citizen of What Country? USA																																				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black																																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (10-12) College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry LEE LUMBER JACK																																						
	17. Father's Name (First, Middle, Last) Kamson Dixon				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH CRIBBS																																						
	19a. Informant's Name/Relationship (Type, Print) FRANCES CRIBBS, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 CHILTON STREET BALTIMORE MD 21210																																						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN Star Cemetery		20c. Location - City or Town, State 3/19/96 Catonsville, MD																																						
	21. Signature of Funeral Service Licensee Gerald Harris				22. Name and Address of Facility CHARTER - Harris F.H. 5540 REISTERSTOWN ROAD BALTIMORE MD 21215																																						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																										
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">e. Arteriosclerotic Cardiovascular Disease</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="6">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. Arteriosclerotic Cardiovascular Disease							Due to (or as a consequence of):							Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):						c. Due to (or as a consequence of):						d. Due to (or as a consequence of):						
	Immediate Cause (Final disease or condition resulting in death)	e. Arteriosclerotic Cardiovascular Disease																																									
Due to (or as a consequence of):																																											
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):																																									
		c. Due to (or as a consequence of):																																									
d. Due to (or as a consequence of):																																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																											
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																					
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																											
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MARCH 4, 1996																																					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANN DIXON M.D. 111 Penn Street, Baltimore, Maryland 21201																																											
31. Date filed (Month, Day, Year) MAR 12 1996				32. Registrar's Signature John A. [Signature]																																							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06966

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Ann Celich

2. Date of Death

Mar 6, 1996

3. Time of Death

10.30 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Church Home Hos

4b. City, Town, or Location of Death

Baito

4c. County of Death

N/A

5. Social Security Number

21314-8098

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 16, 1930

9. Birthplace (State or Foreign Country)

W. VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baito

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1739 E North Ave

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Charles Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Joseph Celich / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

349 S. Pulaski St Baito, MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion Cem

Date

Mar 8, 1996

20c. Location - City or Town, State

Baito, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Betts Funeral Home
1129 N. Caroline St. Baito, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 1 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. S/P Infection for Lung cancer

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

0-1815-1

29d. Date signed (Month, Day, Year)

3-7-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHI-SHIANG CHEN 98 N. Broadway Baito MD 21231

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

96 06967

ITEM: 1. PER F.H. FILM g-733 3/12/96 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emma Eleanor Crosby				2. DATE OF DEATH MONTH DAY YEAR 03 09 1996		3. TIME OF DEATH 10:40PM	
4. SOCIAL SECURITY NUMBER 218-05-7053		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 28, 1908	
9a. FACILITY NAME (If not Institution, give street and number) Maryland Masonic Home				9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Cockeysville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 300 International Circle				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Telephone Operator		16b. KIND OF BUSINESS/INDUSTRY Retail Store			
17. FATHER'S NAME (First, Middle, Last) Howard Ely				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor (unknown)			
19a. INFORMANT'S NAME (Type/Print) Maryland Masonic Home				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 International Circle Cockeysville, Maryland 21030			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park March 12, 1996		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George J. Farnase				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebral vascular accident</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>atrial fibrillation</u>						Approximate Interval Between Onset and Death 3 days	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER June Breiner MD				29c. LICENSE NUMBER D40208		29d. DATE SIGNED (Month, Day, Year) 3/11/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) June Breiner 1205 York Rd Ste 32c Lutherville Md 21093							
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE John Andrew Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

1950-1951

96 06968

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>CATHERINE LORETTA CORCORAN</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>7</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>11:40 PM</u>	
4. SOCIAL SECURITY NUMBER <u>109-20-4356</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>67</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Dec. 6, 1928</u>	
8. BIRTHPLACE (State or Foreign Country) <u>New York</u>		9a. FACILITY NAME (If not institution, give street and number) <u>St. Joseph Medical Center</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Towson</u>		9c. COUNTY OF DEATH <u>Baltimore County</u>	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore City</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>329 Taplow Road</u>		10f. ZIP CODE <u>21212</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 yrs</u> College (1-4 or 5+) <u>College</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Courtroom Clerk</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Judicial</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Ducan</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Agatha Murphy</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Ms. Sharon L. Corcoran</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5908 Brackenridge Avenue, Baltimore, MD 21212</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Green Mount Crematory</u>		DATE <u>3/11</u>		20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Martin D. Lawson</u>		22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Wiedefeld Home</u> <u>6500 York Road, Baltimore, Maryland 21212</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <u>ASCVD</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. <u>Cardiac Arrest</u> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Frank H. Morris M.D.</u>				29c. LICENSE NUMBER <u>D18406</u>		29d. DATE SIGNED (Month, Day, Year) <u>3-8-96</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Frank H. Morris, M.D. 7505 Osler Drive, Suite 409, Towson, Maryland 21204</u>							
31. DATE FILED (Month, Day, Year) <u>MAR 12 1996</u>		32. REGISTRAR'S SIGNATURE <u>J. A. ...</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

asp

ITEM: 3. PER MEO FILM G-733

3/29/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

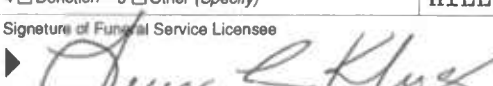
Certificate of Death

Reg. No.

96 06969

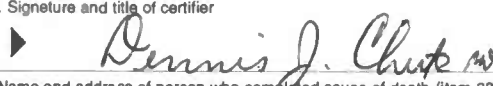

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) ROBERT ROWE COVINGTON, JR				2. Date of Death Month MARCH Day 07 Year 1996		3. Time of Death 1:00 AM	
4a. Facility Name (If not Institution, give street and number) 1705 SELMA AVE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
5. Social Security Number 214-46-0876		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 8, 1942	
9. Birthplace (State or Foreign Country) BALTIMORE							
Usual Residence of Decedent							
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location ARBUTUS		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1705 SELMA AVENUE				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: VIETNAM		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) COLLEGE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry INVENTORY	
17. Father's Name (First, Middle, Last) ROBERT ROWE COVINGTON, SR.				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH ROEPER			
19a. Informant's Name/Relationship (Type, Print) MRS. ELIZABETH COVINGTON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 SELMA AVENUE - ARBUTUS, MD. 21227			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP.		Date 3/8/96		20c. Location - City or Town, State TOWSON	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Carcinoma Schizophrenia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 07, 1996	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) MAR 12 1996				32. Registrar's Signature 			

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06970

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Emery Childs					2. Date of Death Month Day Year March 7, 1996		3. Time of Death 7:40 PM		
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL					4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 081-34-9751		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 9 1944		9. Birthplace (State or Foreign Country) NEW YORK	
	Usual Residence of Decedent					10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
To Be Completed by Funeral Director	10a. State MD,		10b. County FREDERICK		10c. City, Town or Location FREDERICK		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 1104 TANEY AVE.					10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH. College (1-4or 5+) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK			16b. Kind of Business/Industry RESTAURANT			
	17. Father's Name (First, Middle, Last) ALBERT CHILDS Albert Childs					18. Mother's Name (First, Middle, Maiden Surname) RUTH ALLEN				
	19a. Informant's Name/Relationship (Type, Print) JOHN CHILDS (BROTHER)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 TANEY AVE. FREDERICK, MD. 21701				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GRACELAND CEM.		20c. Location - City or Town, State 3/15/96 ALBANY, NEW YORK				
	21. Signature of Funeral Service Licensee Gary L. Rollins					22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 21701 100 WEST ALL SAINTS ST. FRED. MD.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. SEVERE COPD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AIDS									
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier [Signature]					29c. License number D1462C		29d. Date signed (Month, Day, Year) Mar 8, 1996			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PG-720526 MD 501 W 9 th St Frederick MD 21701										
31. Date filed (Month, Day, Year) MAR 12 1996										
32. Registrar's Signature John J. [Signature]										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06971

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert JEROME COOK				2. Date of Death Month March Day 8 Year 1996		3. Time of Death 3:54 PM	
	4a. Facility Name (If not Institution, give street and number) FRANKLIN SQUARE HOSPITAL				4b. City, Town, or Location of Death BALTIMORE COUNTY		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-34-8564		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) FEBRUARY 17, 1938	
	9. Birthplace (State or Foreign Country) BALTIMORE, MARYLAND							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE COUNTY PERRY HALL			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 7 A RAYLON DRIVE				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRESSMAN		16b. Kind of Business/Industry CHARLES PRINTING	
	17. Father's Name (First, Middle, Last) JERRY J. COOK				18. Mother's Name (First, Middle, Maiden Surname) ANNA JOAN SALTYSKI			
	19a. Informant's Name/Relationship (Type, Print) MARIE E. COOK (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 A RAYLON DRIVE PERRY HALL, MARYLAND 21236			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY MARCH 12, 1996		20c. Location - City or Town, State BALTIMORE, MARYLAND			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility LASSAUN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Cardiopulmonary failure secondary to generalized</u> Due to (or as a consequence of): <u>sepsis</u> b. <u>Arteriosclerotic cardiovascular disease</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D-09383		29d. Date signed (Month, Day, Year) March 9, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles F. O'Donnell MD - 111 Hamlet Hill Rd. Baltimore MD 21240								
31. Date filed (Month, Day, Year) MAR 12 1996		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06972

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMANUEL SINGLETON DUPPINS

2. Date of Death

Month Day Year
MARCH 10, 1996

3. Time of Death

4:15 a

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-34-0775

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC 28, 1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

421 N. LAKEWOOD AVE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 5-57-8-57

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

RAILROAD CO

17. Father's Name (First, Middle, Last)

CLARENCE DUPPINS

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET SAUNDERS

19a. Informant's Name/Relationship (Type, Print)

JOAN DUPPINS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 N. LAKEWOOD AVE BALTO, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA

Date

MAR

20c. Location - City or Town, State

13, 1996 OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BETTS FUNERAL HOME

1129 N. CAROLINE ST BALTO., MD 21213

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. NECROTIZING FASCIITIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA, LEFT PNEUMOTHORAX, DIABETES

HYPERTENSION, PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M6236

29d. Date signed (Month, Day, Year)

March 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID J. BRADLEY, MD JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8522

5



96 06973

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Willis Abrahms DeMoss</u>				2. DATE OF DEATH MONTH <u>March</u> DAY <u>8</u> YEAR <u>1996</u>		3. TIME OF DEATH <u>9:11 P M</u>	
4. SOCIAL SECURITY NUMBER <u>215-09-2100</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>81</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Aug. 3, 1914</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9. FACILITY NAME (If not institution, give street and number) <u>Saint Joseph Medical Center</u>			
10. CITY, TOWN OR LOCATION OF DEATH <u>Towson</u>				11. COUNTY OF DEATH <u>Baltimore County</u>			
12a. STATE <u>Maryland</u>		12b. COUNTY <u>Baltimore County</u>		12c. CITY, TOWN OR LOCATION <u>Timonium</u>		12d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13a. STREET AND NUMBER <u>2434 Chetwood Circle, Apt 201</u>				13b. ZIP CODE <u>21093</u>		13c. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (8-12)</u>		19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Salesman</u>		20. KIND OF BUSINESS/INDUSTRY <u>Pharmaceuticals</u>			
21. FATHER'S NAME (First, Middle, Last) <u>Willis Abrahms DeMoss, Sr</u>				22. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Clementine Emma Heller</u>			
23. INFORMANT'S NAME (Type/Print) <u>Mrs. Janice K. Lukowski</u>				24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4755 Stonehurst Road, Liverpool, N.Y. 13090</u>			
25a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		25b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Green Mount Crematory</u>		25c. DATE <u>3/11</u>		25d. LOCATION — City or Town, State <u>Baltimore, Maryland</u>	
26. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Martin D. Lawson (M00358)</u>				27. NAME AND ADDRESS OF FACILITY <u>Mitchell-Wiedefeld Home</u> <u>6500 York Road, Baltimore, Maryland 21212</u>			
28. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Abdominal Aortic Aneurysm</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>Coronary Vascular Collapse</u> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
29. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
30. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				31. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		32. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
33. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		36a. DATE OF INJURY (Month, Day, Year)		36b. TIME OF INJURY <u>M</u>		36c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
37a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				37b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
38. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
39. SIGNATURE AND TITLE OF CERTIFIER <u>Charles F. O'Donnell, MD</u>				40. LICENSE NUMBER <u>D-09883</u>		41. DATE SIGNED (Month, Day, Year) <u>3/10/96</u>	
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <u>Charles F. O'Donnell, MD - 11111 Hill Rd - Baltimore Md</u>							
43. DATE FILED (Month, Day, Year) <u>MAR 12 1996</u>				44. REGISTRAR'S SIGNATURE <u>John A. H. H. H.</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06974

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen

2. Date of Death

January 30 1996

3. Time of Death

5:14 AM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-09-2271

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-20-1897

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2421 FAIT AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6 YRS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

PETER KUCKI

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MRS. JEANETTE FISHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2421 FAIT AVENUE BALTO. MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY ROSARY CEMETERY 2-6

Data

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

Charles R. Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME

2525 FLEET ST. BALTO. MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aspiration pneumonia

Due to (or as a consequence of):

c. Multi-infarct dementia

Due to (or as a consequence of):

Approximate interval Between Onset and Death

hours

2 days

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jack Obeid MD

29c. License number

P08809

29d. Date signed (Month, Day, Year)

January 30, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jack Obeid / Good Samaritan Hospital / Baltimore, MD 21239

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

John A. Carroll

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06975

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND PERRY DANNER SR.				2. Date of Death Month Day Year MARCH 04, 1996		3. Time of Death 1250 PM	
	4a. Facility Name (If not institution, give street and number) 521 RABBIT HILL ROAD RABBIT HILL				4b. City, Town, or Location of Death ANNAPOLIS RIVA		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 223-10-7980	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 30, 1916	9. Birthplace (State or Foreign Country) VIRGINIA	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location ANNAPOLIS			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1920 MARCONI CIRCLE			10f. Zip Code 21401		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 8TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRAINMAN		16b. Kind of Business/Industry RAILROAD			
	17. Father's Name (First, Middle, Last) THOMAS WESLEY DANNER			18. Mother's Name (First, Middle, Maiden Surname) SARAH ALICE JONES				
	19a. Informant's Name/Relationship (Type, Print) RAYMOND P. DANNER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 RABBIT HILL ROAD - RIVA, MD 21140				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PK		Data 3/8/96	20c. Location - City or Town, State ELKRIDGE		
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229					
	23a. Part I. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) e. <u>Head injuries</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) Found 3/4/96		28b. Time of Injury 1230 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) son's home		28d. Describe how injury occurred Subject fell down stairs				
		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1920 Marconi Annapolis, Maryland						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 05, 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201								
31. Data filed (Month, Day, Year) MAR 12 1996								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

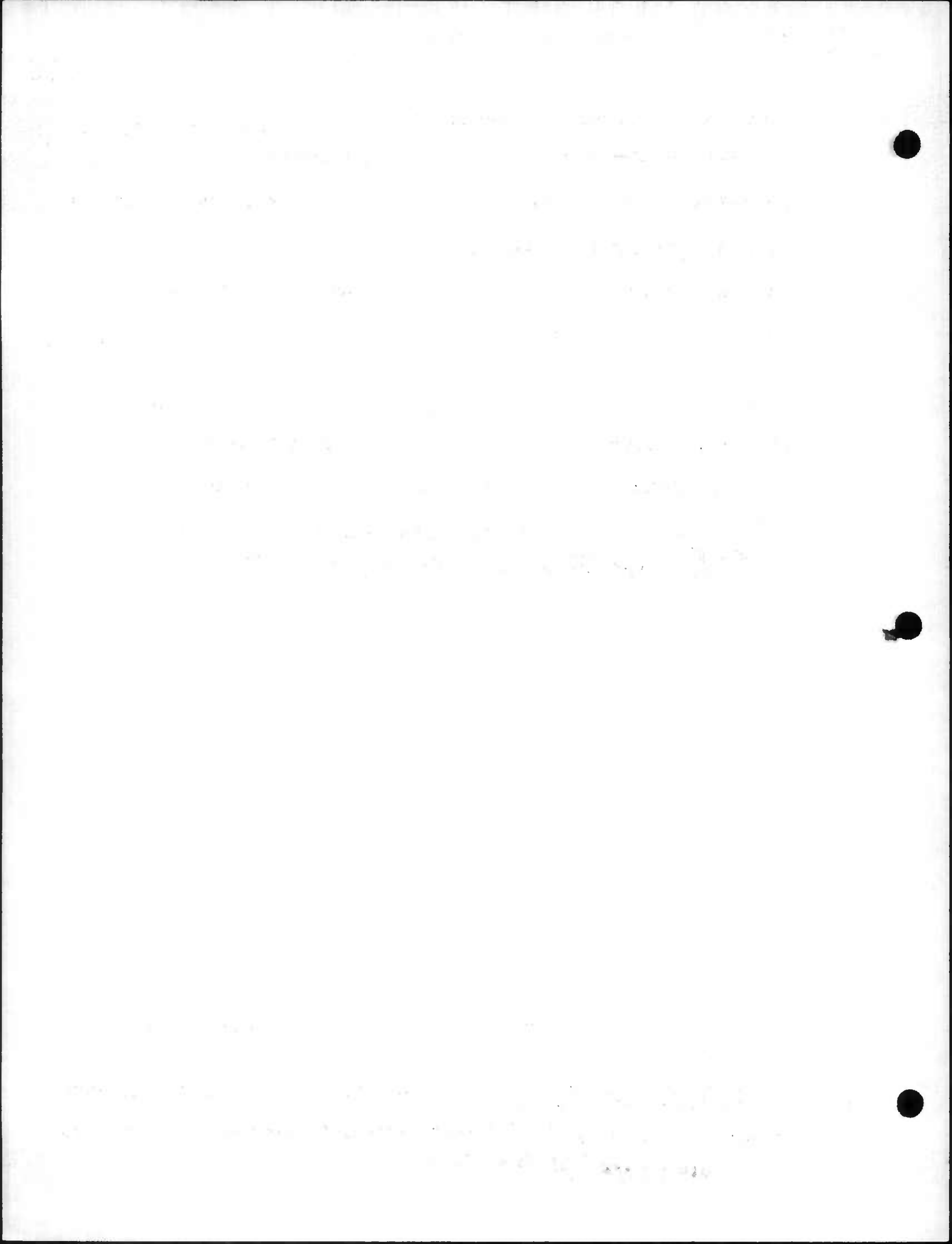
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06976

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARVIN DAVIS		2. Date of Death Month FEB. Day 26 Year 1996		3. Time of Death 4:22 PM
	4a. Facility Name 4320 CLARE WAY APT. A		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number UNKNOWN	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) UNKNOWN Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) UNKNOWN		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 4320 CLARE WAY, APT. A		10f. Zip Code 21213		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) CLERK		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry U.S. GOVERNMENT		
	17. Father's Name (First, Middle, Last) HENRY DAVIS		18. Mother's Name (First, Middle, Maiden Surname) ROSE UNKNOWN		
	19e. Informant's Name/Relationship MRS. GAIL McSORLEY (GRANDNIECE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5435 TORRESDALE AVE. PHILADELPHIA, PA 19124		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP -		20c. Location - City or Town, State 3-8-1996 BALTIMORE, MD
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M
State Registrar	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier CLARON COCKE MD		29c. License number O.C.M.E.
29d. Date signed (Month, Day, Year) FEB. 27, 1996		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CLARON COCKE MD 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) MAR 12 1996		32. Registrar's Signature John A. Duvall			

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96 06977

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rose Duvall				2. DATE OF DEATH MONTH March DAY 11 YEAR 1996		3. TIME OF DEATH 2:05 PM	
4. SOCIAL SECURITY NUMBER 218-38-3604		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1916	
8a. FACILITY NAME (If not institution, give street and number) Medbridge Nursing Home				8b. CITY, TOWN OR LOCATION OF DEATH Rossville		8c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 119 Old Maple Court				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse's Aid		16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) Louis Leon Morris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Magdalene Schlickemiser			
19a. INFORMANT'S NAME (Type/Print) Donald Dreyer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Old Maple Court Baltimore Md. 21221			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial 3/14/96 Baltimore Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Acute Myocardial Infarction				Approximate Interval Between Onset and Death < 1 Hr.	
		DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease				5 yrs.	
		DUE TO (OR AS A CONSEQUENCE OF): Hypertension				5 yrs.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D 25391		29d. DATE SIGNED (Month, Day, Year) 3-12-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601- Loch Raven Blvd Baltimore MD 21239							
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE J. A. Anderson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06978

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas M. Dixon		2. Date of Death Month 3 Day 7 Year 96		3. Time of Death 1120AM
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital		4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll
Funeral Director	5. Social Security Number 220 01 5403	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 19, 1911	9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md.	10b. County Carroll	10c. City, Town or Location Sykesville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 6340 Freedom Ave.		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4or 5+) -		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steam Fitter		16b. Kind of Business/Industry Springfield Hospital		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles Marshall Dixon		18. Mother's Name (First, Middle, Maiden Surname) Edna Bell Day		
	19a. Informant's Name/Relationship (Type, Print) Ruth M. Dixon		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6340 Freedom Ave. Sykesville, Md. 21784		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park		20c. Location - City or Town, State 3/11/96 Sykesville, Md.
	21. Signature of Funeral Service Licensee Harry W. Haight		22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784		
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Electromechanical Dissociation Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier John Ricketts MD					
29c. License number D39296					
29d. Date signed (Month, Day, Year) 3/7/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Ricketts MD CCGH Westminster MD 21157					
31. Date filed (Month, Day, Year) MAR 12 1996					
32. Registrar's Signature John Ricketts					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

96 06979

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED DORSEY				2. DATE OF DEATH MONTH MAR DAY 09 YEAR '96		3. TIME OF DEATH 12:50 P. M.	
4. SOCIAL SECURITY NUMBER 212-14-9679		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 7, 1920	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 23 Locust Drive			
10f. ZIP CODE 21228				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) William Owens				18. MOTHER'S NAME (First, Middle, Maiden Surname) Selma E. Eversmeier			
19a. INFORMANT'S NAME (Type/Print) Ridgely Harry Dorsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Locust Drive Catonsville, Maryland 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Lorraine Park Cemetery March 12, 1996		20c. LOCATION — City or Town, State Woodlawn, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Intracerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 7 hrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER P07530		29d. DATE SIGNED (Month, Day, Year) MAR 10 '96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BAHANNA BAHETHI ST AGNES HOSPITAL BALTIMORE MD 21229							
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06980

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMERSON G. EDMONDS				2. DATE OF DEATH MONTH DAY YEAR MAR 05 1996				3. TIME OF DEATH 1:10 p.m.	
4. SOCIAL SECURITY NUMBER 217-03-7490		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 4, 1919		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Church Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER S. Durham Street 114				10f. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW-2		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 NA				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Security Guard		15b. KIND OF BUSINESS/INDUSTRY Security			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown					
19a. INFORMANT'S NAME (Type/Print) Charles Makowski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eastern Ave. 7500 Balto., Maryland 21224					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) Parkwood March 8		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Rojneck</i>				22. NAME AND ADDRESS OF FAMILY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., MD. 21224					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTROINTESTINAL BLEEDING DEHYDRATION								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Bokhari M.D.</i>				29c. LICENSE NUMBER D-26594		29d. DATE SIGNED (Month, Day, Year) MAR 05 1996			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RIAZ BOKHARI M.D. 100 NORTH BROADWAY BALTIMORE, MD 21231									
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE <i>Jubin Studson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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96 06981

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Pauline Friedlander</i>				2. DATE OF DEATH MONTH DAY YEAR <i>March 08 1996</i>		3. TIME OF DEATH <i>6:55 AM - M</i>	
4. SOCIAL SECURITY NUMBER <i>216-01-0893</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>93</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 20, 1902</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>LEVINDALE</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		8c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>MARYLAND</i>				10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>6946 MILBROOK PARK DRIVE, APT. 2-A</i>			
10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>OWN HOME</i>			
17. FATHER'S NAME (First, Middle, Last) <i>HARRY GELVAR</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ROSE BELLUS</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MR. MORTY ESTERSTON (NEPHEW)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7005 BOXFORD ROAD BALTIMORE, MD 21215</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>BETH ISAAC ADATH ISRAEL 3-8-1996-BALTIMORE, MD</i>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D. Lewis</i>				22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. J. ... Physician</i>		29c. LICENSE NUMBER <i>D44817</i>		29d. DATE SIGNED (Month, Day, Year) <i>MARCH 08 1996</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SUNIC P. RADANT 2434 W Belvedere Ave, Baltimore</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 12 1996</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 06982

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TYRONE FAIRLEY				2. Date of Death Month MARCH Day 9 Year 1996		3. Time of Death 9 PM		
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL				4b. City, Town, or Location of Death ELLCOTT		4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 216-58-2079	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 26, 1951		9. Birthplace (State or Foreign Country) BALTIMORE, md	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County n/a -howard		10c. City, Town or Location ELLCOTT			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 3118 RAMBLEWOOD ROAD			10f. Zip Code 21043		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 th College (1-4or 5+) -			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPING			16b. Kind of Business/Industry UNION MEMORIAL HOSP.		
	17. Father's Name (First, Middle, Last) JEROME ELAM				18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY FAIRLEY				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) VERNA LEAK - sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4012 BALFEN AVENUE, BALTIMORE, MD 21213					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD NATIONAL CEMETERY		Date 3-13		20c. Location - City or Town, State LAUREL, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility WM. C. MARCH FH.-1101 E. NORTH AVENUE					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. BRONCHOGENIC CARCINOMA Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D 29909		29d. Date signed (Month, Day, Year) MARCH 10, 1996	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SCOTT MAURER MD 9501 OLD ANNAPOLIS RD ELLCOTT CITY MD 21042									
31. Date filed (Month, Day, Year) MAR 12 1996				32. Registrar's Signature 					

96 06983

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA E. FIELDS				2. DATE OF DEATH MONTH DAY YEAR MARCH 11, 1996		3. TIME OF DEATH 8:40 AM	
4. SOCIAL SECURITY NUMBER 215-03-3686		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 11, 1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Riverview Nursing Centre		9b. CITY, TOWN OR LOCATION OF DEATH Essex	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Essex				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1 Eastern Blvd.	
10f. ZIP CODE 21221				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tavern Operator		16b. KIND OF BUSINESS/INDUSTRY Tavern	
17. FATHER'S NAME (First, Middle, Last) Walter Lamka				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna			
19a. INFORMANT'S NAME (Type/Print) Calvin Webb				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Cubhill Road Baltimore Md. 21236			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cemetery 3/13/96 Dundalk Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia, old cerebrovascular accident arteriosclerotic coronary vascular disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Michael Schwartz				29c. LICENSE NUMBER D9667		29d. DATE SIGNED (Month, Day, Year) 3-11-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MICHAEL SCHWARTZ 606 HAMMONDS LANE 21225							
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE John Anderson-Rodall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

96 06984

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Youta Foy				2. DATE OF DEATH MONTH March DAY 11 YEAR 1996		3. TIME OF DEATH 1:10 A.	
4. SOCIAL SECURITY NUMBER 166-50-8642		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 3, 1900	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. CITY, TOWN OR LOCATION OF DEATH Catonsville		10. COUNTY OF DEATH Baltimore	
9a. FACILITY NAME (If not institution, give street and number) Charlestown Care Center							
RESIDENCE OF DECEDENT				10a. STATE Maryland			
10b. COUNTY Carroll				10c. CITY, TOWN OR LOCATION Eldersburg			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 106 Taft Terrace			
10f. ZIP CODE 21784				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (9-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Harry Hoffman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl E. Unknown			
19a. INFORMANT'S NAME (Type/Print) Virginia Bien (Niece)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Taft Terrace Eldersburg, Maryland 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery March 13, 1996		20c. LOCATION — City or Town, State Baltimore, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. A. Witzke	
22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Cellulitis DUE TO (OR AS A CONSEQUENCE OF): Sequently flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death weeks weeks			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Andrew Lewis				29c. LICENSE NUMBER D47447		29d. DATE SIGNED (Month, Day, Year) March 11, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew Lewis, 711 Madison Church Lane, Catonsville, Maryland							
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE John Andrew Lewis			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				96 06985	
CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Edna Elizabeth Fritz				2. DATE OF DEATH MONTH DAY YEAR March 8 1996		3. TIME OF DEATH 12:00 P M	
4. SOCIAL SECURITY NUMBER 219-10-8394		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 11 1925	
9a. FACILITY NAME (If not institution, give street and number) South 46'th Street 603				9b. CITY, TOWN OR LOCATION OF DEATH Dundalk		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER South 46'th Street 603				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Orphaned		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home maker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Harry Horning				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Allender			
19a. INFORMANT'S NAME (Type/Print) Edward V. Deems				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loganview Dr. 3524 Dundalk, MD. 21222			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oaklawn March 11		20c. LOCATION — City or Town, State East Point, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., MD. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert A Bradsky MD				29c. LICENSE NUMBER D45343		29d. DATE SIGNED (Month, Day, Year) 3/8/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert A Bradsky 600 N Wolfe St Balt MD 21287							
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06986

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUCY B. GILL

2. Date of Death
Month Day Year
3 6 963. Time of Death
18:30 pm

4a. Facility Name (If not institution, give street and number)

CATONSVILLE CONV. CENTER

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

217-14-1569

6. Sex
☐ M ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

DEC. 21, 1911

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number

1207 ARUNAH AVENUE

10f. Zip Code

21228

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

at own home

17. Father's Name (First, Middle, Last)

JOSEPH WILKERSON

18. Mother's Name (First, Middle, Maiden Surname)

JENNY JONES

19a. Informant's Name/Relationship (Type, Print)

LUCY KIRKLAND - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7505 FAIRBROOK ROAD, apt. 2D, BALTIMORE, MD #44

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

3-11

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Daphne E. Lewis

22. Name and Address of Facility

March F. H. East 1101 E. North Ave.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Atherosclerotic Cardiovascular disease
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/o Cerebrovascular Accident; H/o Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicida ☐ Homicida28a. Date of Injury
(Month, Day, Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28t. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. Lewis

29c. License number

D17537

29d. Date signed (Month, Day, Year)

3-8-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN S. SALUJIA MD 1600 W. MOUNT Royal Ave, Balto 21217

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

John A. Harrison

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06987

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Naomi Grimes

2. Date of Death

March 9, 1996

3. Time of Death

1312 P.m.

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

226-20-4756

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 12, 1910

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9612 Orpin Road

10f. Zip Code

21133

10g. Citizen of What Country?

U. S. A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Trading Post

17. Father's Name (First, Middle, Last)

Jessie Williamson

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Branson

19a. Informant's Name/Relationship (Type, Print)

Doris Wyche - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9612 Orpin Road Apt 204 Randallstown, Md 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Men Park

Data

3/13/96

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Doris Wyche

22. Name and Address of Facility

March F.H. West 21215
4300 Wabash Avenue Baltimore, Md23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardio pulmonary Arrest

Due to (or as a consequence of):

b. Failure to thrive

Due to (or as a consequence of):

c. Depression

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward Sherman MD

29c. License number

D19171

29d. Date signed (Month, Day, Year)

Mar 11-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8620 Liberty Road Randallstown, Md 21133

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06988

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Green

2. Date of Death

March 10th, 1996

3. Time of Death

4:00 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bm Secours Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

229-16-4552

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 6, 1920

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

414 LYNDAURST ST.

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONGSHOREMAN

16b. Kind of Business/Industry

SHIPPING

17. Father's Name (First, Middle, Last)

GEORGE GREEN

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED CHURCHILL

19a. Informant's Name/Relationship (Type, Print)

LUCILLE B. GREEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

414 LYNDAURST ST, BALTIMORE MD, 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUS MTD.

Date

3/15/96

20c. Location - City or Town, State

ARBUS MTD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

GARY P. MARSH FUNERAL HOME P.A.
270 FRED HILTON PASS BALT. MD, 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Respiratory Failure

Due to (or as a consequence of):

b.

Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 days

14 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Sarcoidosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] House officer

29c. License number

D45148

29d. Date signed (Month, Day, Year)

March, 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ricarda J. Osorio Bm Secours Hospital

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

96 06989

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Florian Gall				2. DATE OF DEATH MONTH DAY YEAR March 09, 1996		3. TIME OF DEATH 3:55 p M	
4. SOCIAL SECURITY NUMBER 337-10-8882		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 03, 1907	
9a. FACILITY NAME (If not institution, give street and number) 1724 Robinson's Lane		9b. CITY, TOWN OR LOCATION OF DEATH Fallston		8. BIRTHPLACE (State or Foreign Country) Czechoslovakia		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Fallston		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1724 Robinson's Lane				10f. ZIP CODE 21047		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Realtor		16b. KIND OF BUSINESS/INDUSTRY Real Estate			
17. FATHER'S NAME (First, Middle, Last) John Gall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor Brantalik			
19a. INFORMANT'S NAME (Type/Print) Kenneth John Gall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Robinson's Lane Fallston, MD 21047			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/11/96		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>dehydration</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>progressive dementia</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER David S. Dunn				29c. LICENSE NUMBER D32299		29d. DATE SIGNED (Month, Day, Year) March 11, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN 615 W. MacPhail							
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE Julia A. Hurd			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06990

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THERESA W. HEDRICK

2. Date of Death

Month
MARCH

Day

11,

Year

1996

3. Time of Death

4:15 A.M.

4a. Facility Name (If not institution, give street and number)

227 Altamont Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-22-4062

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept 22, 1927

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

227 Altamont Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ADMINISTRATOR

16b. Kind of Business/Industry

DISTRIBUTION

17. Father's Name (First, Middle, Last)

Thomas Weatherall

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. Pumphrey

19a. Informant's Name/Relationship (Type, Print)

CHERYL SHOOK (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1831 Cook Farm Court - Pasadena, Md. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Memorial Pk

Date

3/14

20c. Location - City or Town, State

Elkridge

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue-Baltimore, Md 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. Due to (or as a consequence of):

Cardiovascular arrest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10yrs.

4yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26294

29d. Date signed (Month, Day, Year)

3/11/94

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1101 Harden Choice Lane Balto. MD 21229

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

96 06991

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE Y. HOWE				2. Date of Death Month Day Year 3 13 96		3. Time of Death 6:30 pm			
	4a. Facility Name (If not Institution, give street and number) 6535 LOUDON AVE. 6535 Loudon Ave				4b. City, Town, or Location of Death Elkridge		4c. County of Death HOWARD			
Funeral Director	5. Social Security Number 215-16-0452		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR 23, 1906		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Howard		10c. City, Town or Location Elkridge			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6535 Loudon Ave.				10f. Zip Code 21227		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Jacob Yost				18. Mother's Name (First, Middle, Maiden Surname) Minnie Brunk					
	19a. Informant's Name/Relationship (Type, Print) Nancy L. Sipes - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11034 Berrypick Lane, Columbia, Md. 21044					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		Date 3/13/96		20c. Location - City or Town, State Elkridge, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Large vessel coronary</u> Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate interval Between Onset and Death months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) MAR		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 								29c. License number 024781
29d. Date signed (Month, Day, Year) 3/11/96										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. CHARLES R. GRAHAM, JR - 716 MIADEN CHOICE LANE-SUITE-205-CATONSVILLE, MD 21228										
31. Date filed (Month, Day, Year) MAR 12 1996		32. Registrar's Signature 								

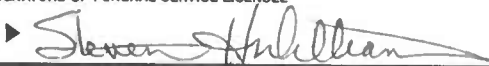

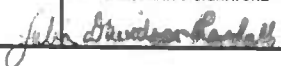
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

96 06992

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GERTRUDE M. HEADLEY				2. DATE OF DEATH MONTH DAY YEAR March 8 1996		3. TIME OF DEATH 18:30 P. M.	
4. SOCIAL SECURITY NUMBER 224-44-4519		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 14, 1926	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1814 ARBUTUS AVENUE				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7TH GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VOLUNTEER		16b. KIND OF BUSINESS/INDUSTRY VETERAN HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) VINCENT HILL MUNSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED ATWOOD			
19a. INFORMANT'S NAME (Type/Print) FERNE HARTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 832 WEDGEWOOD ROAD-BALTIMORE, MD 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) QUANTICO NAT'L CEMETERY 3/15		20c. LOCATION — City or Town, State QUANTICO, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY FIBROSIS AND EDEMA DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA AND BROCHIOITIS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 6 WKS 6 WKS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D41843		29d. DATE SIGNED (Month, Day, Year) March 11, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ann E. Reed St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229							
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06993

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA M. HOLDCRAFT

2. Date of Death

Month
MARCHDay
9,Year
1996

3. Time of Death

11:30AM

4a. Facility Name (If not institution, give street and number)

715 MAIDEN CHOICE LANE-HV-611-CHARLESTOWN

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-74-1241

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 7, 1901

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 MAIDEN CHOICE LANE-HV-611

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

Collegiate (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

CHARLES MUND

18. Mother's Name (First, Middle, Maiden Surname)

LOUISA M. ALBRECHT

19a. Informant's Name/Relationship (Type, Print)

JOHN C. HOLDCRAFT (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

402 FOREST LANE - CATONSVILLE, MD. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVET CEMETERY

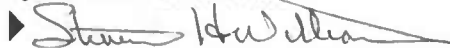
Date

3/13

20c. Location - City or Town, State

FREDERICK, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Ischemic Heart Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D47447

29d. Date signed (Month, Day, Year)

March 11, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andrew Carbis 711 Maiden choice Lane Catonsville Maryland

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

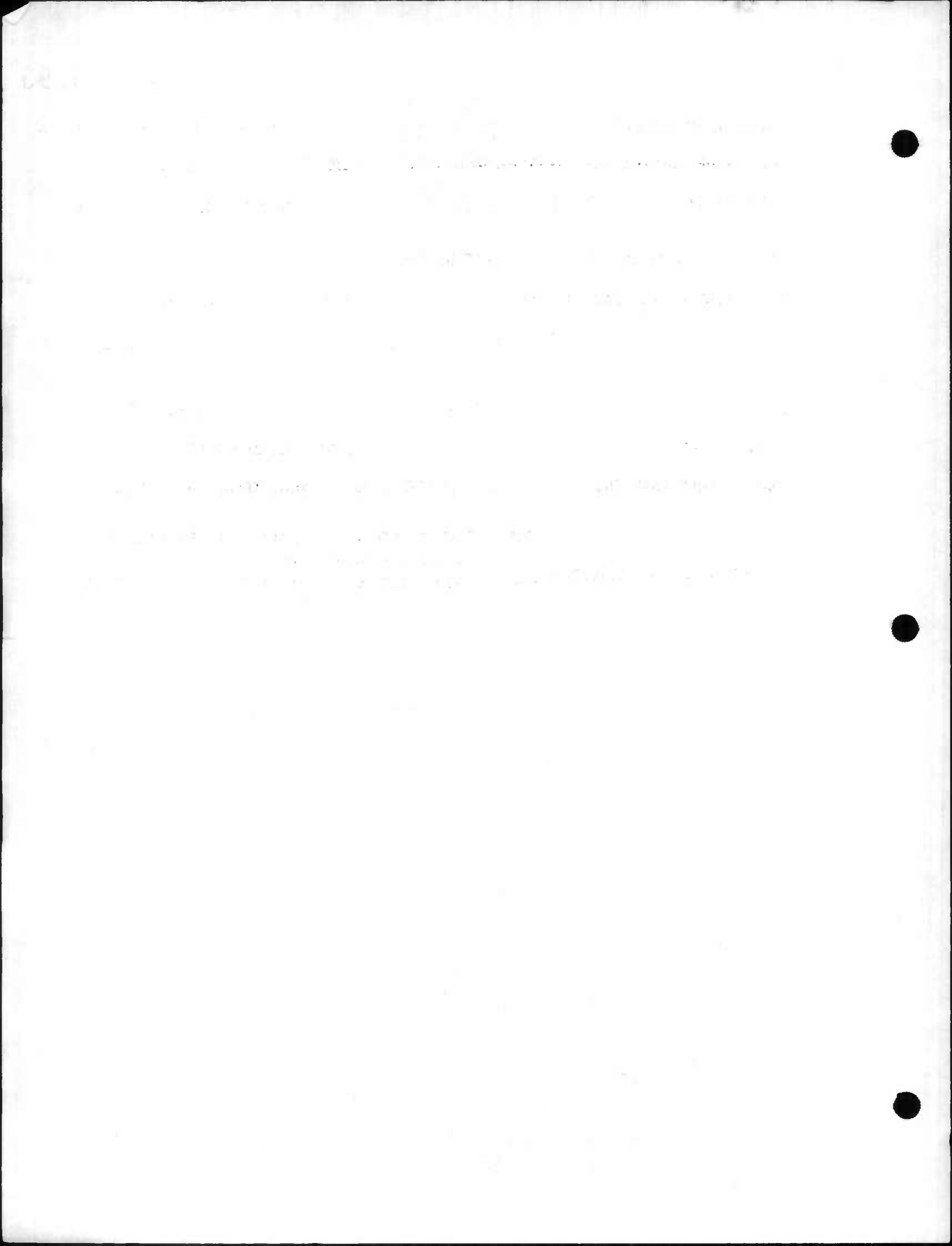
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 06994

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gordon Grant Hinkle, Sr.				2. DATE OF DEATH MONTH DAY YEAR March 10, 1996		3. TIME OF DEATH 11:35 p.m.	
4. SOCIAL SECURITY NUMBER 214-40-6379		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 25, 1942	
9a. FACILITY NAME (If not institution, give street and number) Allegis Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 512 Baltic Avenue				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY Industrial Manufacturing Equipment			
17. FATHER'S NAME (First, Middle, Last) Gordon Wallace Hinkle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Mary Bernard			
19a. INFORMANT'S NAME (Type/Print) Gordon Grant Hinkle, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2595 Conway Road Odenton, MD 21113			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 03/11/96		20c. LOCATION — City or Town, State Baltimore, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Brain Ca</u> Approximate Interval Between Onset and Death <u>unknown</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g.			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D27569		29d. DATE SIGNED (Month, Day, Year) March 11, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen Hinkleman 1777 Reisterstown Rd #365							
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 06995**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

JUDITH A. HICKMAN

2. Date of Death

Month Day Year
MARCH 6, 1996

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

1650 KIRKWOOD ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-62-7215

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 27, 1952

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1650 KIRKWOOD ROAD

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BILLING SPECIALIST

16b. Kind of Business/Industry

MEDICAL SERVICES CO.

17. Father's Name (First, Middle, Last)

ELLSWORTH RAHE

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE QUICK

19a. Informant's Name/Relationship (Type, Print)

CHARLES W. HICKMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1650 KIRKWOOD ROAD - BALTIMORE, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

3/9/96

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

►

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic breast cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Paul Gormley MD

29c. License number

D18557

29d. Date signed (Month, Day, Year)

MAR 7 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PAUL GORMLEY - 900 CATON AVENUE - DEPARTMENT OF ONCOLOGY - BALTO., MD 21229

31. Date filed (Month, Day, Year)

MAR 12 1996

32. Registrar's Signature

Subi

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

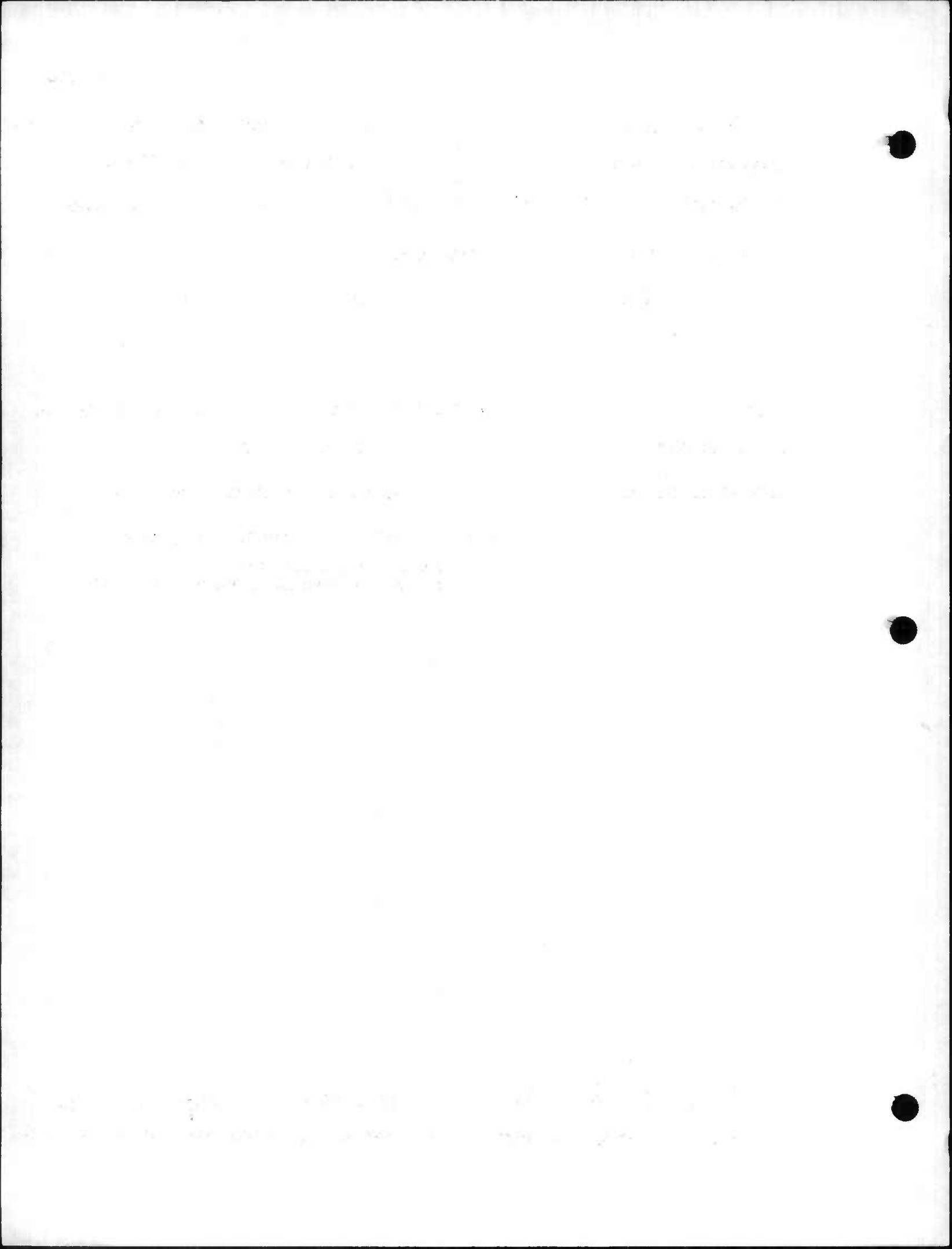
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 06996

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Minnie Hochman		2. Date of Death Month March Day 5 Year 1996		3. Time of Death 12:53 PM
	4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT HOME		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 052-07-2106	8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	9. Birthplace (State or Foreign Country) LITHUANIA		8. Date of Birth (Month, Day, Year) JULY 14, 1905		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 7920 SCOTTS LEVEL ROAD		10f. Zip Code 21208		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Collage (14 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) MORRIS KATZ		18. Mother's Name (First, Middle, Maiden Surname) FANNIE HOROWITZ		
	19a. Informant's Name/Relationship (Type, Print) MRS. SHIRLEY JASIE (SISTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8081 SUNRISE LAKES DRIVE, # 309 SUNRISE, FL 33322		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hebron		20c. Location - City or Town, State Flushing, N.Y.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sol Levinson & Bros. 6010 Reisterstown Rd, Baltimore MD 21215		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION 10 MINUTES Due to (or as a consequence of):				
	b. ACUTE CORONARY ARTERY OCCLUSION 1 MINUTE Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS - INSULIN DEPENDENT.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number 015140		29d. Date signed (Month, Day, Year) 3/6/96
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IAN SUNSHINE, MD, 6220 PARK HEIGHTS AVE, BALTIMORE, MD				
	31. Date filed (Month, Day, Year) MAR 18 1996				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 06997

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY E. HICKS				2. Date of Death Month MARCH Day 10 Year 1996		3. Time of Death 6:15am																				
	4e. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death A.A. COUNTY																				
Funeral Director	5. Social Security Number 413-30-1418		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 28, 1924	9. Birthplace (State or Foreign Country) TENN.																			
	Usual Residence of Decedent																										
To Be Completed by Funeral Director	10a. State MD.	10b. County ANNE ARUNDEL	10c. City, Town or Location ODENTON			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
	10e. Street and Number 1336 PASSAGE DRIVE				10f. Zip Code 21113		10g. Citizen of What Country? USA																				
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 08		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry RETAIL SALES																				
	17. Father's Name (First, Middle, Last) JOHN SCHACH JR.				18. Mother's Name (First, Middle, Maiden Surname) DECIE ELLIOTT																						
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) GLEN D. HICKS SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1336 PASSAGE DRIVE ODENTON MD 21113																						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LAKEMONT CEMETERY		Date 3-13-96	20c. Location - City or Town, State DAVIDSONVILLE MD.																					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD. GAMBRIELLS MD. 21054																						
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. CHRONIC RENAL FAILURE</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. INSULIN DEPENDENT DIABETES MELLITUS</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c. HYPERTENSION</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td></td> <td>d. DYSLIPIDEMIA</td> <td>Years</td> </tr> <tr> <td></td> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC RENAL FAILURE	Years	Due to (or as a consequence of):		b. INSULIN DEPENDENT DIABETES MELLITUS	Years	Due to (or as a consequence of):		Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. HYPERTENSION	Years	Due to (or as a consequence of):			d. DYSLIPIDEMIA	Years		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC RENAL FAILURE	Years																									
	Due to (or as a consequence of):																										
	b. INSULIN DEPENDENT DIABETES MELLITUS	Years																									
	Due to (or as a consequence of):																										
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. HYPERTENSION	Years																									
	Due to (or as a consequence of):																										
	d. DYSLIPIDEMIA	Years																									
	Due to (or as a consequence of):																										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CORONARY ARTERY DISEASE ANEMIA VARIABLES DYSRHYTHMIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred																			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																											
29b. Signature and title of certifier 				29c. License number D17891		29d. Date signed (Month, Day, Year) 3/10/96																					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID RUST, M.D. SUITE 500 200 HOSPITAL DRIVE GLEN BURNIE MARYLAND 21061																											
31. Date filed (Month, Day, Year) MAR 12 1996																											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.


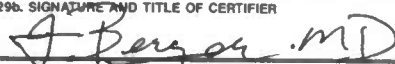

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

96 06998

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William H. Hackley				2. DATE OF DEATH MONTH February DAY 26 , YEAR 1996				3. TIME OF DEATH 7:36 p.m.		
4. SOCIAL SECURITY NUMBER 228 26 9684		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7. DATE OF BIRTH (Month, Day, Year) March 4, 1925				8. BIRTHPLACE (State or Foreign Country) Virginia						
9a. FACILITY NAME (If not institution, give street and number) Malcolm Grow USAF Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Andrews AFB				9c. COUNTY OF DEATH Prince Georges		
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Suitland				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3707 Dionna Road				10f. ZIP CODE 20746				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor		16b. KIND OF BUSINESS/INDUSTRY Apartment Building						
17. FATHER'S NAME (First, Middle, Last) Frank Hackley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Bryant						
19a. INFORMANT'S NAME (Type/Print) Helen Hall-Niece				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Red Bud Lane, N.E., Leesburg, VA 22075						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Northern VA Crematory		DATE 2-28		20c. LOCATION — City or Town, State Arlington, VA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Affordable Funeral Services 9929 Murnane Street, Vienna, VA 22181						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 1hr		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Diabetes Mellitus								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER  J. Berger, M.D.				29c. LICENSE NUMBER D25925				29d. DATE SIGNED (Month, Day, Year) February 27, 1996		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Berger, M.D. 7720 Wisconsin Avenue, Suite 205, Bethesda, MD 20814										
31. DATE FILED (Month, Day, Year) MAR 12 1996				32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

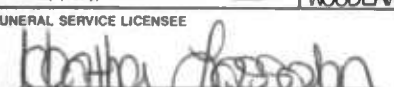

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96 06999

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH E. HOUSEMAN				2. DATE OF DEATH MONTH Mar DAY 10 YEAR 1996		3. TIME OF DEATH 3:30 am	
4. SOCIAL SECURITY NUMBER 215-09-6639		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	7. DATE OF BIRTH (Month, Day, Year) JULY 1, 1909		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE - TIMONIUM		10c. CITY, TOWN OR LOCATION BALTIMORE COUNTY		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 80 EAST PADONIA ROAD				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY-ASSESSMENT OFFICE		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE COUNTY			
17. FATHER'S NAME (First, Middle, Last) JOHN EDGAR SHILLING				18. MOTHER'S NAME (First, Middle, Maiden Surname) EFFIE ELIZABETH BARNES			
19a. INFORMANT'S NAME (Type/Print) EDITH MAY DOYLE (SISTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 ELINOR AVENUE BALTIMORE, MARYLAND 21236			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY MARCH 14, 1996		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY LASSAUN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. ISCHEMIC BOWEL SECONDARY TO CARDIAC EMBOLISM					Approximate Interval Between Onset and Death HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. CONGESTIVE HEART FAILURE, RECURRENT					YEARS
		c. VALVULAR HEART DISEASE					YEARS
		d. OSTEOPOROSIS WITH VERTEBRAL COMPRESSION FRACTURE S					YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
HYPOTHYROIDISM						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
RESTRICTIVE LUNG DISEASE (secondary to xiphosis)						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ceballos, M.D.				29c. LICENSE NUMBER D 25886		29d. DATE SIGNED (Month, Day, Year) 3. 10. 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CEBALLOS, M.D. ST. JOSEPH HOSPITAL 7420 York Rd Towson, MD 21204							
31. DATE FILED (Month, Day, Year) MAR 12 1996		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 07000

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marion William Haines				2. Date of Death Month March Day 10 Year 1996		3. Time of Death 8:55		
	4a. Facility Name (If not institution, give street and number) Sykesville Elder Care Center				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 220 16 5488		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 8, 1911	9. Birthplace (State or Foreign Country) W. Va.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md.		10b. County Carroll		10c. City, Town or Location Sykesville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number Bartholow Road.				10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High School		College (1-4or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide		16b. Kind of Business/Industry Springfield Hospital		
	17. Father's Name (First, Middle, Last) Minor Ashby Haines				18. Mother's Name (First, Middle, Maiden Surname) Iva Albright				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Geraldine L. Lawrence				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Rolling Ridge Dr. Westminster, Md. 21157				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery		Date 3/12/96		20c. Location - City or Town, State Gamber, Md.		
	21. Signature of Funeral Service Licensee <i>Harry W. Haight</i>				22. Name and Address of Facility Haight Funeral Home P.O.B. 195 Sykesville, Md. 21784				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. pancreatic cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	Approximate Interval Between Onset and Death 3 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Thomas M.D.</i>		29c. License number D 47704		29d. Date signed (Month, Day, Year) 3/11/96					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRUNG PHAM, 777 ERROR 7445 Furnace branch, Glenburnie MD 21060									
31. Date filed (Month, Day, Year) MAR 12 1996		32. Registrar's Signature <i>John Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

